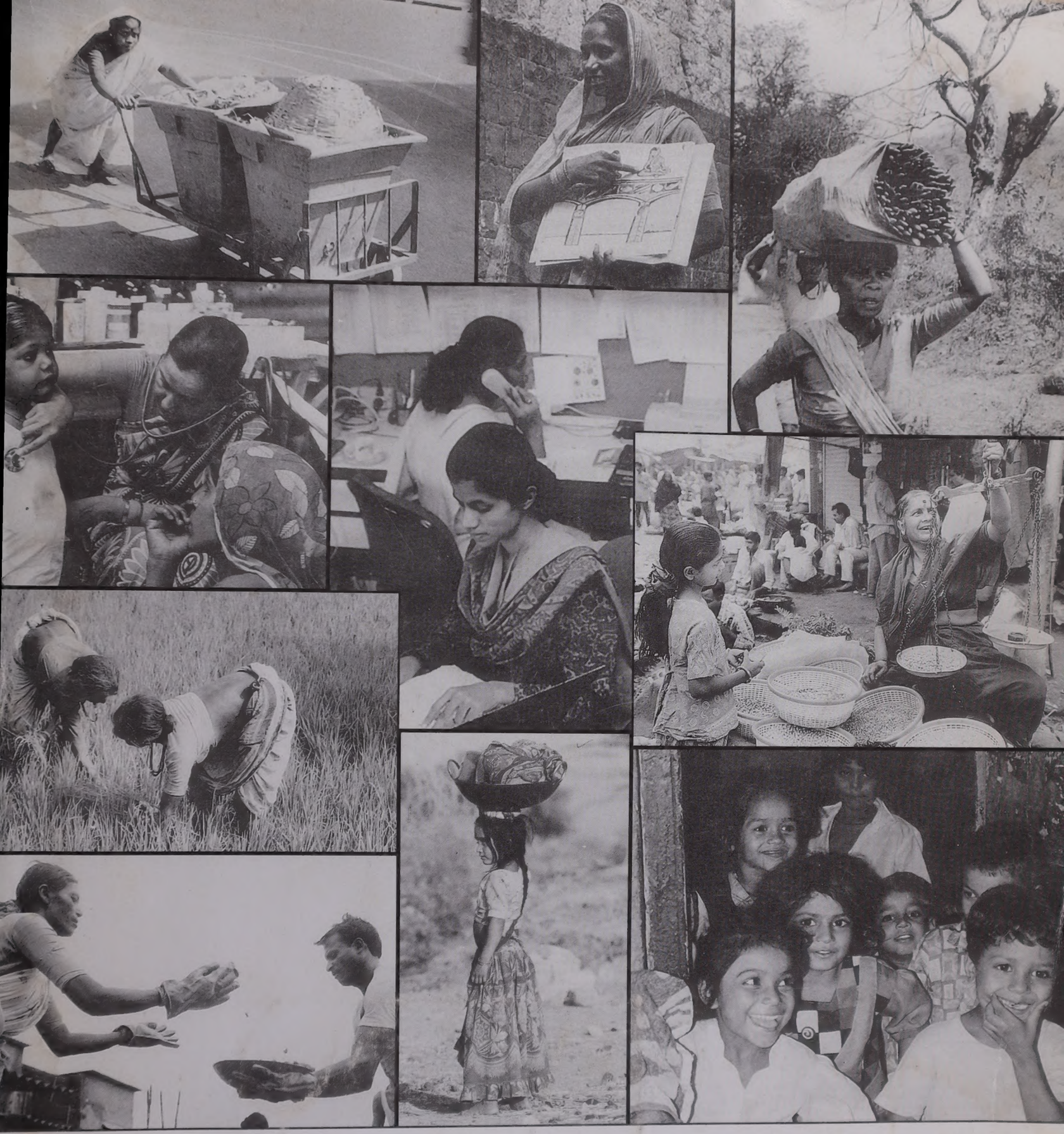

HEALTH, HOUSEHOLDS AND WOMEN'S LIVES

A study of illness and childbearing among women in Nashik district, Maharashtra

Cehat

Neha Madhiwalla
Sunil Nandraj
Roopashri Sinha

Health, Households and Women's Lives

A Study of Illness and Childbearing among Women in Nasik District, Maharashtra

Neha Madhiwalla

Sunil Nandraj

Roopashri Sinha

Cehat

Research Centre of Anusandhan Trust
2nd Floor, BMC Bldg., 135, Military Road, Next to Lok Darshan
Marol, Andheri (East), Mumbai 400 059, India
Tel: (91)(22) 851 9420, Fax: (91)(22) 850 5255
Email: cehat@vsnl.com

Pune Office:
2/10, Swanand, Aapli Sahakari Society, 481,
Parvati, Pune - 411 009. India
Tel: (91) (020) 444 3225, Phonefax: (91) (020) 444 7866
Email: cehatpun@vsnl.com

June 2000

Printed by :
Parkar Arts, India Printing House, 42 G. D. Ambekar Marg, Wadala, Mumbai - 400 031.

Acknowledgements

Firstly, we would like to thank all the women who participated in this study for their warmth, their patience and the trust they placed in us. We would like to thank all the Panchayat members, aanganwadi workers, ANMs, and MPWs for their help in organising meetings in the villages and for providing us with information and help during field-work.

We would like to thank all our field staff whose enthusiasm, hard work, commitment and deep understanding of women's problems exceeded all our expectations. We would like to thank Ratna Mohod, Vaishali Jadhav, Jayashree Jadhav, Smita Mahadik, Mangala Lakhan, Sunita Parab, Savita Parab, Aarti Dicholkar, Manisha Mane, Vijaya Nimle, Jyoti Pawar, Geeta Pawar, Kavita Jawalekar, Shaila Rokade, Venu Sonawne, Surekha Sabale, Kalpana Gangurde, Seema Kute, Anjali Lolage, Archana Sakhalkar.

We would like to thank our team member, Amar Jesani, for his consistent support, advice and help. His presence in the team was a great source of strength and inspiration.

Our thanks to the staff of Vachan, especially Shaku Akka, Vishebhau and Purnima for their selfless help and support to us in the field. Our thanks to the entire organisation for giving us so much warmth and love. Our thanks to the social workers and field workers of the UBSP project for their help in identifying slum settlements in Nasik.

We would like to thank all our consultants, Ravi Duggal, Malini Karkal, Vibhuti Patel, Usha Lokhandwala, Arun Bal, Anil Pilgaonkar, Gracie Fernandes, Dhruv Mankad and Anita Borkar, for their guidance and help.

We would like to thank the entire staff of CEHAT for their support and co-operation throughout the long duration of the study.

We would like to thank all the experts who spent time to go through the first draft of the report and give extensive comments and suggestions and also participated in the consultation meeting - Dr Indra Munshi, Dr. Lakshmi Lingam, Dr. Ghamshyam Shah, Dr. Veena Shatrugna, Dr Leena Abraham, Dr. Madhura Swaminathan, Dr. Ajay Mahal, Dr. Ravindra Soman and Dr. Ashwin Patel and Sonya Gill. We would like to thank Smruti Koppikar for editing the report.

Finally, we would like to thank the John T. and Catherine D. MacArthur Foundation for its generous grant, which allowed us to conduct this study.

We must add that although we have greatly benefited from the advice, help and suggestions received from all those mentioned above, the errors and omissions in this report are our own.

Table of contents

1. Introduction

It is the convention to narrate stories of everyday lives of women in health studies, but here their stories also serve as a reminder of the complex world they live in. This study attempts to convert vital information on their health into numbers, while simultaneously focussing on the complexity of their problems.

Shamabai, 40, is a Thakur tribal living in a remote village with three young daughters. Reaching the village means a four kilometre walk up a steep hill. No wonder, they call that hill 'Crying face'. Since there is no work for agricultural labourers in the village, they must travel to nearby villages to work in the four-month rice cultivation season. Shama's husband worked as a temporary worker in the railways. When he was critically ill, a year ago, helped by his colleagues, she took him all the way to Mumbai for treatment. For a brief while, Shamabai who had barely travelled ten kilometres from her home was catapulted into a complex and bizarre world of modern medicine and bureaucracy. Despite the treatment, her husband died. She still does not know what the ailment was. Now, she is back in her village that has no electricity, no water and no work. However, her brief stay in the city has changed her subtly. She speaks broken Marathi, she can imagine what city life is like and *she is now aware of how medical care can spare the people of her village pain and suffering.*

Godavari has greyed, having seen more of the world than most women would have, as wife of a former police patil. Freed from usual social restraints, in old age, she travelled across half the taluka with our research team. Her family lives in a small isolated outhouse in their fields. When she gets lonely, she hoists her grandson on her hip and walks the half kilometre to the main village with ease. A month after we first met her, she and her entire family were in a frenzy to pack in the rice crop before another unseasonal shower. She has turned dark in the sun and a little frail from the overwork and disturbed mealtimes. *She uses a little of the massage oil that she has brought for her husband for her own legs. She discounts the occasional aches and pains.*

Isabel lives in a shack on a pavement in Nashik. Her two elder daughters have been sent away to Mumbai to work as domestic maids. Isabel's husband does not always come home at night. When he does, he wants money and vents his frustration on his wife. After a long day at work, Isabel is often too tired to walk around the boundary wall and prefers to jump her way home. She had done it hundreds of times before her pregnancy but *this time she slipped and fell. She lost the child, but with Christmas approaching soon, she has no time to grieve or rest.*

Tarabai's life is by no means wasted. With one son doing very well in Nashik and the other two busy farming, she has no financial worries. Her house is the largest and best in the village. If only her husband's health would improve. She displays a sheaf of medical records she has collected in the last 14 years as he lay completely bed-ridden. He even has to be carried to the toilet. He seems to have lost the will to recover. *With her husband in such a state, no one seems to have noticed Tarabai sinking into a quiet depression of her own.*

Zubaida is an aanganwadi worker. She seemed lucky to live in a village so close to Igatpuri town to get LPG for cooking. It made her work at the crèche so much easier. One day, the pressure cooker burst in her face. As the only person in the village, who is paid a government 'salary' (meagre as it may be), entertaining all official visitors is solely her responsibility. We too were directed to her. *Even this serious accident did not relieve her from this duty.* Too badly burnt to wear a blouse, she spoke to us from behind a curtain. In spite of the pain, she sat up and tried to talk to us, till a woman panchayat member relieved her.

Kanchan has a fairly comfortable life. She lives in an independent bungalow in one of Nashik's most prosperous areas. Apart from his small business in the town, her husband earns a good income from agriculture in their village. After seven years of marriage, she is getting

desperate about having children. They went all the way to Baroda in search for a cure for her 'infertility'. *All the cures have been tried on her and have failed. And yet her husband has never thought of going through any treatment himself.*

Gauri, 17, is mentally retarded. Her left hand is paralysed and she moves with difficulty. *Only once, she was taken to the PHC, when she had malaria. She was taken by S.T bus, she fell down and nearly got run over.* She can barely talk. However, she has learnt to protect herself from the children who tease her by throwing stones at them. She spends her entire day picking reeds and flowers near her house. Her family has no land - not even a steady home. They migrate to any place where they can find work. There is only one man in the family, fifteen year old Dattu. He does all the chores that his sister would have otherwise done. During the agricultural season, he and his mother migrate for work to the more prosperous villages that grow grapes and ground nut. Gauri stays behind in the care of her old grand mother, who fends for them both by tending to someone else's cow. When the cow bears a calf, they earn a fairly decent sum. But the old woman must drag herself and Gauri to the market to sell it...

THESE STORIES are among the most dramatic but almost all women share fairly similar experiences. The stories provide pointers and direction to our analysis. For example, we were struck by the fluidity in the boundaries of women's family and work lives. We witnessed that women were not only dependent on the family's resources, but were also instrumental in generating them. There was no co-relation in the authority that women enjoyed and the care they took of themselves. Autonomy and responsibility seemed to make them more, rather than less, vulnerable to neglect themselves. The poverty of a household influenced women differently from others. Similarly, the poverty of entire villages and settlements made women's lives more difficult. We made an attempt to understand the multiple layers of the social life that women inhabit. The recognition that women live and struggle in this hierarchical, inequitable society forms the basis of this study.

The objectives of the study

Primarily the objective was to study the health problems of women in rural and urban areas of Nashik district; the kind of health care they get, if at all; how much money is spent on this care; and to understand differences in all these on the basis of gender, age and other social factors.

Review of past household studies

WITH EVERY study, our understanding of the inter linkages between socio-economic, political and environmental factors with health is deepened. Studying ill health in a community by conducting household surveys of perceived morbidity has become an important part of health research in India. Notably, in the past decade, four attempts have been made to conduct country-wide studies by the National Sample Survey (1986-87, 1995-96) and National Council for Applied Economic Research (NCAER) (1990, 1993) to study morbidity, health care utilisation and expenditure through the use of household surveys. Apart from these, numerous small-scale studies have been conducted using the same methodology. The most significant among those include studies conducted in Jalgaon (FRCH, 1986-87), Madhya Pradesh (FRCH, 1990) and Kerala (KSSP, 1987).

The study conducted in Jalgaon, Maharashtra (Duggal and Amin, 1989) was a pioneering effort aimed at documenting household strategies of healthcare. The under-five population and the elderly population had the highest morbidity. The rural sample had a morbidity prevalence rate of 154.66 in comparison to the urban rate of 141.85. There was also an unexpected pattern of morbidity in relation to consumption expenditure class, in that the class that used more health care reported more morbidity. Infections, including fevers constituted the largest category of illness accounting for 32.6 of the total episodes. About ten per cent of the illnesses were not treated while as much as 77 per cent of the health facilities utilised were in the private sector. Health care cost was marginally higher in rural than in urban areas.

The 42nd round of the National Sample Survey (NSS, 1992) on morbidity and utilisation of medical services was conducted in 1986-87. Nationally, 81.5 per cent of the ailments in rural areas were treated while urban areas recorded a rate of 89 per cent. Private doctor as a source of treatment was preferred by 51.83 per cent nationally. A similar percent was recorded for Maharashtra. The average total expenditure per treatment was Rs. 84.93 (Rs 86.59 in Maharashtra)in rural areas and Rs. 91.30 (Rs 136.55 in Maharashtra) in urban areas.

The Kerala Sastra Sahitya Parishad (Kannan, 1991) conducted a household survey in rural Kerala to record mortality, morbidity and utilisation of health care. It recorded an unprecedented rate of morbidity and a particularly high prevalence of chronic illness. Morbidity was highest among children under five years and persons aged over 50 years. The prevalence of acute and chronic illnesses among women was marginally higher as compared to men. The KSSP study also found high utilisation of private health services and considerable use of self-care which accounted for 12 percent of health services utilised. The per capita cost of treatment was Rs. 16.56 with 50 per cent spent on medicines and fees accounting for 18 percent.

The NCAER conducted a household survey of medical care in 371 districts of the country covering 18,102 households (NCAER, 1992). The survey was conducted in May-July 1990. Overall rural morbidity was recorded as higher than urban morbidity. As this survey recorded only treated illnesses, there was a substantial difference in the prevalence rates for male and female adults and children. In Maharashtra, the morbidity in urban areas was recorded as being lower than the national average. The rural morbidity prevalence rate was also lower in Maharashtra. Fevers were recorded as being the most prevalent illness in both rural and urban households. The cost per treated episode was recorded higher in the rural areas than in urban areas.

In the same year, a micro study was conducted by F.R.C.H in Sagar and Morena districts of Madhya Pradesh (George et al, 1994). The study recorded a monthly morbidity prevalence of 310.78 per thousand persons. The rate of prevalence differed for rural and urban households and for acute and chronic illness. The rural rates of prevalence were 156.53 per thousand and 132.32 per thousand for acute and chronic illnesses respectively while the rates were 179.07 and 121.06 respectively in urban areas. For women, morbidity was significantly higher after the age of 25 years and increased with age. As high as 69 per cent of treatment facilities were in the private sector with no significant rural-urban difference. The cost per illness episode was Rs. 134.23 with doctors' fees and medicines accounting for large portions of the costs. The expenditure on traditional practitioners was much higher in the case of females as compared to males. However, overall expenditure on males and females did not differ much.

In the summer of 1993, NCAER conducted another national household survey on health care utilisation and expenditure (Sundar R., 1995). The monthly prevalence of morbidity was 106.7 episodes per thousand for the rural areas and 103.0 per thousand persons for the urban areas with no significant difference in male and female morbidity. The study reported very high morbidity for the aged population though. In Maharashtra, the rate of illness among rural women was much lower than the all-India average. Similarly, urban women in Maharashtra showed a lower rate of morbidity. Nationally, the use of private practitioners was marginally higher in urban areas. Private facilities were used more in Maharashtra than the all-India average. The expenditure per non-hospitalised episode in the rural areas was recorded as Rs. 90.48, the equivalent figure in the urban sample being 113.93. The figures for Maharashtra were higher, being Rs. 90.71 and Rs. 136.93 per episode for rural and urban areas respectively. While the expenditure on health care in rural Maharashtra was similar to the all-India average, in urban Maharashtra, the expenditure was marginally higher.

The most recent large-scale household health survey was conducted by NSS in the 52nd round in 1995-96. It recorded a monthly prevalence rate of 86 episodes per thousand for the rural areas (male-84, female-89) and a rate of 84 per thousand for the urban areas (male-81, female-89). Tuberculosis was found to be

the most prevalent chronic illness. The survey reported that 83 per cent of those reporting illness were given treatment in the rural areas while the figure was 91 per cent for urban areas. There was no significant difference among males and females in this respect. The use of health care was more firmly based in the private sector, which accounted for 81 percent of all sources of non-hospitalised health care. Public hospitals accounted for only 11 percent of the total facilities used for non hospitalised care. In Maharashtra less than 32 per cent of both rural and urban hospitalised cases were recorded in the public sector. The average total expenditure per episode for non-hospitalised cases was Rs. 144 in rural areas and Rs. 175 in urban areas. The expenditure on females was lower, being Rs. 137 and Rs. 164 per episode in rural and urban areas respectively.

GENERALLY, we find that the household surveys show a marginally higher morbidity for females than males. Morbidity tends to be higher also among young children and the aged. The prevalence rates have risen gradually over the ten years between 1986 and 1996. The use of health care is higher among males than females in most of the studies, although there is only a slight difference. The use of private health care has been consistently high over the decade, especially in case of non-hospitalised care while non-use of health care is largely because illnesses are not considered serious enough for treatment, although financial problems and non-availability of medical facilities are also important reasons. The expenditure on health care incurred by households has shown a rise in the decade 1986-96, as can be expected due to rising inflation and the continued use of private health care. Significantly, **most of the studies have shown no remarkable gender difference in morbidity utilisation and expenditure on health care. This may be due to the fact that the above studies have not analysed information specifically in relation to women's health.**

The contribution of this study

LARGELY, those studies which recorded age-sex distribution of morbidity, showed that adult women reported higher morbidity than girls. However, no study had attempted to systematically document the nature of the additional illnesses suffered by women after they reached puberty. An important aspect of women's health is the strain put on their bodies by reproduction and the resultant short-term and life-long health problems. Apart from being responsible to meet the partner's sexual needs and reproduction, women must undertake all the tasks that are necessary for the sustaining their households. *How burdensome this role becomes depends on many factors such as the socio-economic condition of the village/ settlement, larger social factors, resources available to the household, the expected number of children she must bear and raise, the number of dependants and the sexual and age-wise division of work within and outside the household.*

We attempted to use the household survey to explore the totality of women's health problems in relation to the varied aspects of their lives.

The utilisation of health care is related to many factors, such as the visibility of the health problems, the availability and access to health care facilities and the control and use of resources within households. Most household surveys have indicated only a marginal difference in the utilisation of health services by men and women. However, **the micro studies done on women's health (especially gynaecological morbidity) have noted that a large proportion of these problems remained unattended.** Importantly, when utilisation of services is low due to poverty and no access to health care, perception of morbidity itself is lowered. Also, women are conditioned into accepting certain health problems as part of life and are unlikely even to expect treatment for them. An important aspect of women's lives relates to childbearing. Childbearing is, in itself, an important health event and has a lasting impact on women's bodies and their perception of well being. The phase of maternity and the use of contraception are, often, the only times, when women come in contact with the medical system and experiences hospitalisation.

It is now widely accepted that much of the health expenditure in India is met directly by households

from their own resources. Household per capita expenditure on health is about three to four times higher than the state per capita expenditure on health. In 1993, the government revenue expenditure was Rs. 70.2 per capita (based on the Health Information of India, Ministry of Health and Family Welfare, Government of India).

However, the gender differentials in household spending on health have never been studied in detail. It is usually found in household surveys, that expenditure on hospitalisation for women during childbirth forms a significant proportion of the total health expenditure made on them. However, expenditure on treatment of non-maternity related health problems is clearly inadequate. **It is worthwhile to evaluate the level of discrimination faced by women with regard to expenditure on health care vis-à-vis the resources available to the household. A study of the maternity events provides insight into women's experience of health and the response of the household to one of the most important health needs of women.**

Also, there is dynamism in society, which is reflected in the shift in perception of ill health (increase in the morbidity prevalence rate), in the pattern of utilisation, (higher use of health care, more dependence on private sector) and in the increased health expenditure (due to increased utilisation, rising prices and greater use of private care). By using this modified methodology, we attempted to explore these relationships.

2. Study Design and Methodology

An important aspect of this study, as stated earlier, is the use of a modified methodology to elicit more information on the specific health problems of women. The design of this study used both quantitative and qualitative methods. A major component of the study was a household survey of morbidity, utilisation and expenditure. In addition to this, we also conducted in-depth interviews with individual women and key informants. This report presents only the findings of the survey of the households. However, the analysis also draws on the valuable insights and convictions that we developed during the qualitative inquiry.

The social distance between the researcher and participant has a great influence on such studies. In addition to that, conventional methodology is inherently biased against marginalised groups. For e.g., the use of standard language and scientific terms alienates a large number of people who have had little or no access to formal education (women, tribals). Nor are these groups accustomed to structuring their experiences in a manner that is intelligible to the urban educated researcher. No study can hope to transcend this distance completely. We believed that conventional methodologies do not do justice to the manner in which, especially women express themselves.

Though it is inevitable that researchers using their own sensibility interpret the responses of the participants, we attempted to structure the women's narratives as little as possible. It became necessary for us at every stage to grapple with the problems of translating unstructured narratives into standardised data. The challenge before us was to use a standard methodology like the health survey and, at the same time, subject it to a critique from the perspective of gender. The aim was not merely to generate information on the households' experience of health and health care, but also explore the extent to which such a methodology can address issues concerning women's health.

Sampling design

The size of the sample was fixed at 1200 households. This number seemed sufficiently large to enable collection of adequate data on illness as well as maternity events and contraception. The decision to select three fourths of the households from the rural sample and one fourth from the urban sample was arbitrary.

The decision to select Nashik district for the study was based on the fact that it is an average-developed district where the socio-economic and demographic profile is not very different from that of the rest of the state. We used the Centre for Monitoring Indian Economy (CMIE) development index as a reference for this selection. (Table 2.1). Within the selected district, we decided to select one taluka, which has a sizeable tribal as well as non-tribal population. Igatpuri taluka was, therefore, selected for the rural sample as it has a sizeable tribal population (48 per cent). Another reason for selecting the taluka was the presence of the organisation VACHAN which has done extensive work, albeit only in the north-eastern tribal belt. It was felt that selecting a taluka with a sizeable tribal population would allow us to better understand the disparities in health within rural society and also understand the specific social and cultural factors that affect health care seeking and perception of illness.

The urban sample was selected from Nashik City and suburbs, as the urban population in Igatpuri taluka was not very large. We also found that Igatpuri town, the only urban centre in Igatpuri taluka, has a very large migrant population and is, thus, not very typical of urban centres in Maharashtra. On the other hand, Nashik offered us more variation in socio-cultural profile and a wider range of health facilities in both the public and private sectors.

Selection of the sample

The selection of the villages was done using three

criteria, size of the village, presence or absence of public health facilities and the proportion of tribal population. Although the villages are clustered on the map (Annexure 4), we took care to include villages with a range of different social, cultural and physical environments. We referred to the 1991 census to ascertain the size of the village, existing public health facilities and the proportion of tribal population. We decided to select every third house in villages having less than 300 households and every fourth house in the larger villages. We continued to select villages till the sample size of 800 households was reached. However, on visiting the villages, we found discrepancies in the census data.

Having recently concluded a survey for below poverty line households, most panchayats had their own list of households. We found that households had greatly increased in the five years following the collection of the census information. Another complicating factor was the presence of 'new villages'. These were enumerated separately in the census reports. However, we included them in the survey as part of the panchayat villages from which these 'new villages' were being separated. On actual mapping, we found that the number of households were smaller than those quoted by the panchayats. We relied on our own enumeration for selection of the households. Voluntary action can substantially influence the economy and also the health behaviour in a concentrated area. Hence, only two villages were selected from the project area of VACHAN.

It was decided to use socio-economic class as the criterion for selecting the urban households. The type of settlement was taken as the single indicator of socio-economic status. Hence, we decided to select 60 percent of the households from slum settlements, while the rest were distributed among apartments and bungalows. The slum clusters were also selected with the help of VACHAN, which had only recently initiated developmental work with women living in slum pockets in the suburban area of Nashik. In addition, a centrally located slum, Ganjmal Shramik Nagar was also selected with the help of UBSP (Urban Basic Services Programme), a programme of the Nashik Municipal Corporation and UNICEF. We found that the slum clusters were well demarcated and fairly small. Thus, we enumerated the entire slum settlements and selected every 2nd household in the smaller clusters and the 3rd household in the larger slum cluster.

For the non-slum households, it was decided to interview households living in flats in Radhaswami Nagar, a middle class area, peopled largely by professional and self-employed persons. Another cluster selected was Shivaji Nagar and its adjoining area; an elite locality consisting of privately owned independent houses. In these clusters, it was not possible to do enumeration. Thus, we contacted each and every household in the selected colonies/ housing societies and selected those who were willing to participate in the survey.

Collection of data

Actual fieldwork was conducted in three phases between September 1996 and December 1996. While we covered the rural households in the first two phases, the urban households were interviewed in the third phase.

We employed 16 investigators for data collection in the rural area and eight in Nashik city. They were all women between 18 and 30 years. Their educational qualification varied, ranging from high school to post graduation. However, the average investigator was matriculate with a year of college education. Seven of the 16 investigators were married women. Of them, six had one or more children. All of them were residing either in Nashik or Mumbai. All except one investigator had spent their childhood and youth in the city. For a majority of the investigators, this was their first experience in doing a survey. Very few, in fact, had done any kind of paid work earlier. The mother tongue of all the investigators was Marathi and they all possessed good ability to read and write that language. The majority of the investigators were Hindu, while a few were Neo-Buddhist.

Initially, there was a period of intensive training of the investigators, (explained below), which was

followed by the actual survey. The survey of the rural households was conducted first. The fieldwork in the rural areas was completed in two phases of three and two week duration each. In the pre data collection phase, the researchers visited the selected villages, established contact with the local leaders and women in the community. We also conducted key informant interviews with women and men in the villages. This initial visit was also used to fix the time and date of the survey. Usually, there was a gap of three or four days between the first visit by the researchers and the arrival of the research team. This time was sufficient for information to spread by word of mouth that such a survey was being planned. In almost all villages, we also held a public meeting for women in the balwadi, samaj mandir or temple to give information about the study, its objectives, the date and the process involved (mapping, sampling, and interview).

This process continued simultaneously with data collection. Thus, while the survey was going on in one village, the researchers would establish contact in the next village. Often, women from one village would have natal homes in the next sampled village. This network of relationships was very useful in reaching out directly to women and households without the mediation of the established leadership (panchayat, health workers, and police patil).

During the entire duration of the survey, we resided in Nashik and commuted to the villages. The villages varied in distance and were difficult to access. In some villages, which had no motorable road, we were required to travel on foot. Two such villages were located on hilltops, involving a climb of one to two hours. On the other hand, some villages were located on the main road at a very short distance from Nashik. However, we took care to cover all the wadis of the village and to follow the entire sampling procedure described above. Each and every respondent met the investigators at least twice -while mapping and during the interview.

As the survey was conducted in the period following the rice-sowing season, in most villages, women were relatively free. They were away from their houses only for a short period for weeding. Most women returned home from work by noon. When informed of the time and date of the survey, women, in fact, stayed at home specifically for the interview. Most interviews were conducted at home. However, in the second phase, where the selected villages had a high proportion of irrigated farming, it was not possible to meet women during the daytime. The work schedule of the women in these villages was different. They worked in the fields from early morning till late evening with a short lunch break at noon. In these villages, fieldwork was done in the early hours of the morning and late evenings and night.

The arrival of the entire research team always evoked a lot of interest in the villages. However, as we had already met the women in the village and informed them about the survey, there was less apprehension and suspicion. The research team would then divide into three or four groups and commence the work of mapping the households in one section/lane/wadi of the village. In some cases, impromptu meetings were again held for small groups of women who wanted to know about the study and the research team. The research investigators did mapping of the villages themselves. Care was taken to ascertain how many households resided in one physical structure (having same house, but different kitchens). Mapping was a process that enabled us to directly interact with each and every woman in the village. This was the time when a pamphlet describing the study, its objectives, information about the organisation and commitment to confidentiality and the rights of the respondents was handed over to the household and explained.

Based on our enumeration of the households, we decided the sample size for that particular village. Generally, a team of two investigators conducted the interview, one asking the questions and the other writing the responses. However, after some weeks, some investigators conducted the interviews alone. The respondent was any woman above twelve years of age who was a member of that household. In the rural areas, it was not uncommon for this respondent to be quickly joined by other women from the household and occasionally men as well. The interviewers made note of all the individuals who

participated in the interview. The questions in the probe list (explained later) which were directed to all women above 12 years of age were, ideally, to be asked in a place that offered privacy. The men were asked to move away from the group so that the women could answer this part of the interview in privacy. However, each woman could seldom be interviewed privately. Mostly, women answered these questions in a group. In cases where some women were not present at the interview, the main respondent answered for all the other women in the household.

On average, each interview took an hour and a half. This included the time spent by the investigators in introducing themselves and the study. The pamphlet described earlier was read out and given to the respondent. The name, age, educational qualification and marital status of each household member were elicited first. This was filled by asking the number of children for all ever-married women and pregnancy /delivery /abortion and contraception use for all currently married women. This was followed by questions on illness in the past one month suffered by all the household members. After recording the symptoms in brief for these episodes, additional illnesses were probed for all women above 12 years in the household. This was followed by recording detailed information on all the episodes reported by each person. Lastly, information on occupation, assets, income, infrastructure and residence were recorded.

Admittedly, all the actual interviews did not follow exactly in the manner outlined above. Quite often, respondents narrated histories of past illnesses, bereavements, family problems etc. Women spoke about losing husband or children, fights with relatives over property, the apathy of in laws or married children, the problems related to work and livelihood, about childbirth in the past, the experience of family planning, surgeries, accidents and serious illnesses. We had anticipated such incidents and our investigators had been trained to listen to these narratives patiently and also to discern what information was relevant for the interview (within reference month, pertaining only to household members) and what was to be recorded as remarks. Often, respondents asked us for advice and health tips. We were shown case papers and medical reports. Children with minor infections were brought forth for inspection. We handed out notes of referral or told them about available facilities. We also advised them as best as we could. Although this information was not strictly relevant for the study, occasionally, it allowed an investigator to follow up information, which was left out by the respondent while answering the interview schedule.

The conduct of field work in the urban area followed exactly the same process. The only difference being that public meetings were often substituted by house-to-house contact. In the apartments and bungalows, a specific date and time for the interview had to be fixed. In the slum households, we encountered many locked houses because it was the festival season and entire families had gone back to their villages for harvesting. This is the reason why all the 400 urban households, which were sampled could not be interviewed.

The interview schedule (Annexure 2)

The survey was conducted using an interview schedule to record all information on the socio economic profile of the household, morbidity, use of health care and expenditure on health care. In addition to this, information on maternity events and contraception for all women in the household was also recorded.

Some of the categories used were as follows:

The household: The household referred to all individuals who shared a common cooking fire. Information on all individuals who had lived in the household in the previous year was recorded.

Reference period: The reference period for recording all episodes of ill health in the households was one month prior to the date of the interview. These included problems starting prior to the reference period and continuing in the reference period, those starting and ending in/ continuing through in the reference period. For maternity events and

contraception, the reference period was one year prior to the interview. The reference period was fixed as one month based on the experience of earlier research studies.

Duration of illness: The duration of illness was recorded as the total duration of the problem as well as the number of days for which the problems afflicted the person in the reference month.

Health care: Health care (upchaar) referred to all actions that were deliberately taken to influence the health problem that had been recorded. This included all aspects of self-care, self-medication, ritual and other practices and the use of all kinds of health care providers, both formal and informal. 'No treatment' consequently, means any situation where none of the above was taken recourse to.

Expenditure: This included all types of payment for goods and services, in cash and in kind, which were made in the reference period.

In this report, some terms, which have been used, need to be explained.

'Women', unless otherwise specified, refers to all female members residing in the household. 'Earners' refers to all individuals who are engaged in wage labour, salaried job, self employed or participate in home based production, including cultivation. 'Non workers' are those who are recorded as not participating even in household work. 'House-workers' are those engaged solely in unpaid household work required for the survival for the household, but not understood as economic production (cooking, cleaning, childcare, and collection of fuel and water). 'Ever married' single women include widows, deserted and divorced women.

'Socio-economic status/class' is not a very precise category. However, it is an occupation-based category used to measure the relative economic status of the household. 'Class' has always been a problematic category to define, especially, for rural households when calculated without an accurate measurement of land and output. However, we chose to use this category in order to understand the effect of income disparity on morbidity and health care utilisation.

'Morbidity' in this study refers to perceived illness, which is any feeling of pain, discomfort, abnormality, which can be perceived and articulated as physical or psychological symptoms by the respondent. It is illness that is not to be equated with disease, which can be identified and classified by the clinician.

Modifications in the methodology

Although not specified in the reports of the studies reviewed in the previous chapter, the favoured respondent is the head of the household. Morbidity is recorded in the form of episodes of acute illness and continuing chronic ailments. Generally, probing is not resorted to. However, as women were the focus of this study, we adopted specific measures to make the study more gender sensitive.

The exclusive use of women respondents and women interviewers. The entire field research team was comprised women. Surprisingly, we found that age and marital status of the investigator was not as significant factors as their self-confidence and the empathy that they developed with the respondent women. The ability to answer questions about the study, tact in questioning and sensitivity in dealing with disturbing information and unforeseen events (such as opposition from male members or aged persons to young women responding to the interview schedule, the presence of a seriously ill person in the household at the time of the interview, a recent death etc.), were key to the investigator's effectiveness. It was imperative for all investigators to be knowledgeable about health and health care, which was achieved through training. In their training, the most important components were imparting to them knowledge about the body and a perspective with which to approach women's problems.

1. ***Use of a probe list (a list of 14 questions probing specific symptoms) to elicit more information on women's health.*** After recording illnesses reported for all the members

of the household by the respondent, a list of symptoms was used to probe for illness among women above 11 years of age. (Annexure 3) It contained elements of both general and reproductive health. The 'Pain during intercourse' and 'problems with using contraception' were the two symptoms to be probed only for among married and cohabiting women. The use of the probe list was not rigid. Investigators asked these questions in the order they preferred. There was also no check on whether all the questions in the probe list had been asked. Quite certainly, questions relating to intercourse and R.T.I s were not asked uniformly to all women due to lack of privacy.

2. ***Intensive training of investigators to make them sensitive to women's health problems and the difficulties that women have in articulating these.*** As stated earlier, we found that the most important part of training was imparting knowledge and perspective to the field team. The training programme emphasised three aspects. First, an introduction to the study, some basic inputs on the research methodology of the study, a complete understanding of the interview schedule, its contents and the method of administering it. Second the knowledge of physiological processes (such as menstruation, childbirth and menopause) and reproductive health problems and contraception, an introduction to a gender perspective to health issues. And the last, basic information of the geographical area, the economy of the villages, customs, language and the status of women in this society. Apart from the formal training programme, considerable training took place from interaction at work.

3. ***Establishing good rapport with the women in the community by holding community meetings and repeated contact with them before commencing the survey.*** The approach adopted in this study was not politically neutral. It was declared, at the outset, that the objective of the study was to highlight women's health problems because they get neglected due to various social and economic reasons. The fact that women are talking to women was stressed. Prior to the survey, we approached women in the villages and slums through participatory organisations such as mahila mandals and women's savings groups or through small meetings in lanes and settlements. A considerable amount of time was spent in ensuring that women understood the objectives of the study and the relevance of it. We also ensured that we had reached out to all sections of the village/ settlements. Thus, in most large villages, where social boundaries were quite definite, we held separate meetings for the dalit settlements and the groups of migrant labourers. As our investigators had already contacted women in their homes, the motivation for women to come to a meeting was higher. We also found out if a section of village's women had stayed away from the meeting and then tried to probe whether there were any undercurrents in the politics of the village that we should be aware of. It was evident that in a meeting, women felt much more emboldened to ask questions and express doubts than when we approached them individually in their homes. It is certain that they felt security in numbers. The fact that the entire survey was being conducted publicly and we were willing to face women in a group also served to establish trust in us. Before each interview, our interviewers read out a pamphlet explaining the objectives of the study, the purpose for the collection of information and the rights of the respondents

Due to the methodology used, we were able to record a significantly higher burden of morbidity and information on non-treatment among women. All the modifications that were made must be viewed in totality. It is not possible for us to estimate the effect of any single factor on the reporting of women's morbidity. The idea was to create an environment that encouraged women to feel free speak about their health problems, even while a deliberate attempt was being made to elicit information about unreported illness through the probe list. This impressed on us the need to be sensitive to women's own perceptions about their health problems. Purely medical or even

sociological categories of illness prove inadequate to record the complexity of illness perceived by women. Although this fact has been stressed in almost all the qualitative micro-studies on women's health, an attempt was made here to integrate these insights into a quantitative study.

Methodological issues

Studies on women's health have used a wide range of methodologies – behavioural studies, conventional surveys, family planning or child health studies. Few studies have focussed on the entire range of health issues concerning women and with the household women as respondents. In household health surveys, women's issues and concerns remained invisible. Women were neither the focus nor respondents of these studies. It was assumed that the knowledge gleaned from these inquiries was relevant equally to both men and women. However, as more attention is given to the continuing disparity between the sexes in the living standards and opportunities available for survival and development, it is clear that the reality of women's lives differs substantially from that of men. Consequently, inequity in health care can hardly be ignored.

In practice, we find that women feel intimidated by the structure of the survey because a majority of women respondents cannot read what is being written about them. Also, we found that surveys were associated with government agencies, which exercise considerable control over people's lives (in terms of assigning 'below poverty line' status or recording land ownership etc.). Nonetheless, we felt that the survey design was the best suited methodology for this study, because there was a need to study variations in the health care situation of a considerably large number of households spread over a large geographical area.

1. One of the most significant issues that this study raises for us is the understanding of reporting of illness. Much of the analysis hinges on this crucial factor. We could find no precedent for the pattern of illness reporting that we found in our study. It forces us to enter into the long-standing debate about the reliability of reported morbidity. It is accepted that 'disease' and 'illness' are different phenomena. Inherent in our classification of health problems as either disease or illness, are certain judgements about severity and importance. Expectedly, the judgements made by experts and the community itself differ. From the perspective of the expert, those health problems which result more often in death or disability, and those which spread quickly among the population are more important. From the point of view of the community, it may be those problems, which severely diminish the quality of life, which are more important. Thus, while maternal mortality may not figure large in the total mortality statistics among women, the impact that a maternal death has on a community is tremendous. The first deaths to be spontaneously recalled in a community survey are maternal deaths.

2. Traditionally, the measurement of ill health and disease in India has been done using data on mortality. However, if we attempt to use data on morbidity, we find the experience of ill health is mediated by various players. The cultural means to experience and articulate bodily experience are pre determined for all of us. It is difficult to set down objective standards to measure and evaluate this experience. Thus, we are compelled to reflect and evolve some explanation for the profile of ill health that we encountered. There are certain universal problems related to the method of collecting data and the coding process. As these problems are not unique to our study, they need wider discussion.

   2.1 The use of a probe list to probe unreported illnesses among women above 12 years had a very dramatic overall effect on the morbidity rates. However, we do find that there is a distinct pattern. The objective of this study is to document all of women's health problems, not just those related to the reproductive system. And the focus of the study included all women, even adolescent girls and women past the reproductive age.

The participant of the study was to be **any** woman who had sufficient information about the household. Nonetheless, we observed a bias on the part of the investigators to select currently married and cohabiting women within the age group of 25-55 years as respondents. The increase in morbidity is most significant for women in this age group. (Table 2.4) Thus, we find a significant co relation between the percentage of women who are main respondents and the probed morbidity rate of that age group. Although as the large majority of the respondents are in the reproductive and productive age, they, for social and biological reasons, should also logically report higher morbidity.

One of the most important methodological issues is the definition of an episode of illness. We find that individuals have reported upto six episodes of illness as occurring in a single month. The problem is what basis must be used for describing an episode. For e.g., if time is taken as the deciding factor, then can two unrelated illnesses (pain during menstruation and an injury) running concurrently be regarded as one episode of illness. On the other hand, if we look for a causal link to define an episode, we must depend on the perception of the women to define the episode. For e.g. does **she** feel that her backache is related to the white discharge (or it could be related to the work that she does.) In actuality, a combination of both these comes into play. This seems to suggest that when we probe for specific complaints, the same illness may be reported as two or more different illnesses. The problem of defining an episode is compounded in our study due to the use of the probe list. A large number of complaints for women are noted on the basis of the list of symptoms. There is considerable subjectivity on the part of the respondent as well as the investigator in combining the complaints into episodes of illness.

At the stage of coding, we took care to incorporate as much detail as possible. Hence, for each episode (called 'aajar') we coded upto three symptoms, upto two perceived causes of illness, the duration of the entire illness and of the duration of suffering in the reference period and the link to any life event, if reported. On the basis of this information, we proceeded to rationalise the construction of episodes for each individual who reported multiple episodes. In spite of this, we find that due to the use of probing, women have reported multiple episodes in greater proportion than men have. (Table 2.5) In addition, we find that for men, 1.39 symptoms are recorded per episode. For women, this figure is 1.49 for unprobed episodes and 1.36 for probed episodes (Table 2.6). Multiple episodes in our study must not be seen to reflect automatically a high quantum of morbidity, but it must be seen as an indicator of the multifaceted nature of women's health problems. We were also constrained in our analysis by the fact that not much attention has been paid to the issue of episode construction in other studies.

3. A related methodological issue was ascertaining the duration of illness. Given the chronic and unrelenting nature of illness among women that we noted, the duration of illness that was reported was in approximate years, in many cases. Even in cases of complaints such as fever or diarrhoea, the duration was reported to be as long as two months. This may have been the result of multiple episodes of the same illness recurring in quick succession or merely an articulation of the prolonged suffering endured by the individual. However, although instructed in all cases, to record the exact date of the start and end of the illness, our investigators often did not probe enough to record the exact duration of the illness. Thus, the data on duration of illness is not very accurate. We have used duration of illness as a variable of analysis selectively. This was done merely to compare the general duration of different types of illnesses and the difference in the treatment of short and long-term illnesses.

4. Another methodological problem that resurfaces in all studies, especially with women respondents is the reporting of information on assets, income

and land holding. When we also asked for information on income and assets, we suddenly transgressed the boundaries of our domain. When the study was declared to be on health, the validity of asking such questions itself was questioned. In the tribal areas, knowledge about ownership of land, quantum of produce etc. among women as well as men was very limited. Besides information that women were able to provide on these aspects was very difficult to standardise. Their measures for land and produce were not those officially used. For example, *avne*, the most widely used term for describing the quantity of land is not a standard measure and cannot be converted into (e.g.) acres. As most rural households had joint incomes from agriculture and traditional crafts, it was impossible to determine the earning status of individual members. We took care to record all economic activity, especially, information on main and subsidiary occupations of each member, so that we did not miss out the unpaid work done by women in their homes and fields. Finally, we decided to rely on the data on occupation, which was most complete, for determining the socio-economic status of the household.

5. Similarly, the problem of recording components of cost in health expenditure. As women are not necessarily participants in the process of purchasing health care, their knowledge of details of health expenditure was poor. In most cases, they were able to report only the combined cost incurred on the use of that particular facility. This was particularly true of their reporting of expenditure when they were not present. However, women are more deeply involved in the management of household finances than acknowledged. Also, there is a strong reason to believe that an event such as health facility utilisation and concomitant expenditure would be discussed in the household. Thus, we find that a complete no response for expenditure is very rare. Given the nature of our health care services, we do find that a single provider (in most cases, a private practitioner) provides medical consultation, medicines as well as conducts other procedures such as suturing and administration of injections, saline.

The ethics of survey research

At the outset, there were many questions facing the research team. The decision of going into a community where we had no roots and no presence was made with many misgivings. Research done by professionals raises many specific ethical issues. This organisation pursues research as an end, not as a means to some other goal. When we declared that this survey was not a precursor to any health programme or scheme, it was but natural that some of the participants should lose interest in the study. However, we ourselves began to ponder on issues related to the act of research. The area that we had selected to study had been witness to innumerable surveys, government sponsored and others, in the past. As with these surveys, it was expected that we would "collect all this information, disappear and do nothing." We reasoned about the need to generate knowledge and information about problems that remain unnoticed or ignored because they concern only marginalised groups. Talking about these problems and acknowledging them was like making a beginning in the long process of change.

Ethical issues in the study

1. Having involved women in the study, the problems of actually making space for them in debates on health became evident. Women spoke about themselves because we were able to articulate what they really experienced in their lives and houses. We, however, were not obliged to speak about ourselves. All our efforts to maintain transparency about our organisation and our objectives, to seek informed consent, and to give information and help when it was sought were entirely voluntary. There is no system of accountability for such studies. Communities and individuals can exert no control over researchers apart from refusing to participate in the study. They may receive assurances about the sincerity

and good intentions with which the information collected will be utilised. However, given the complex process by which knowledge is generated and disseminated, it is difficult even to ascertain where this information has gone and how it has been transformed.

2. Most conventional methodologies position themselves as gender neutral. There is ostensibly no bias towards any sex. The interview schedule, where information is pre-classified into columns and cards is the standard research tool used in health expenditure surveys. Anticipating some of the problems of restricting participants to selecting options pre determined by the researchers, most of the questions in this schedule were open ended. However, it is interesting to note how such a tool is received and transformed in the hands of women investigators and women participants. Our investigators had been instructed to record all additional information as remarks, including their own impressions and experience. The remarkable number and the degree of detail and variety of the 'remarks' convinces us that the survey methodology, in some way, negates women's experience and mode of expression. Many feminist researchers have emphasised that women use different narrative structures and ways of expressions than men. They abhor standard categories. When asked to narrate what happened when someone was ill or was having a child, women could not, or would not, structure their narrative according to the flow of questions in the interview schedule. The flow of their narratives was self determined including whatever they thought was relevant and interesting. Seldom did our respondents restrict themselves to one illness episode or event or to one member of the family at a time. The more involved they felt in the interview, the more complex and intertwined their narratives became. Initially, our investigators were frustrated with the task of reordering this unbroken flow of information according to the sequence of questions. Even after they had mastered this, they continued to write long detailed notes at the back of the questionnaire. Women consistently spoke about much more than what was being investigated, the investigators reciprocated by recording all this information, out of conviction that this information was as relevant as what had been recorded in the columns of the schedule. The dilemma for us has become to integrate this varied and dispersed information into our analysis.

3. Very little has been written about the emotional aspects of quantitative research. During our training, we emphasised the need to develop sensitivity and intimacy. Women responded not merely by answering our questions, but by telling us about their lives and all their problems. We found ourselves listening to life histories and even offering solace and advice. At the end of every day, when a meeting was held to take stock of the work accomplished and the problems encountered, the team members spent hours relating what various women had told them and what they had experienced themselves. The short intense relationships that were established during fieldwork were, in many ways, very distressing. We felt a sense of helplessness that arose from the realisation that not only could we offer very little help to the woman, but that the relationship itself was not long enough to be emotionally satisfying. All that could be achieved was that we learnt to reflect on what we had heard and seen.

The experience of the study made us more aware of the pressures that all women must face in their lives. Just as we aimed to study the effect that gender identities has on the lives of women whom we interviewed, we became more aware of that effect on researchers themselves. We have endeavoured to articulate the problems that we faced in the study in order to create a context in which to view the findings of this study as well as to initiate a discussion on the ethics and politics of research.

Table 2.1: District-wise relative index of development

MAHARASHTRA STATE	
DISTRICTS	**RELATIVE INDEX OF DEVELOPMENT**
Mumbai	704
Pune	157
Thane	128
Nagpur	109
Kolhapur	104
Wardha	99
Raigarh	88
Sangli	87
Solapur, Aurangabad, Jalgaon	85
Satara	83
Nashik	**81**
Ahmadnagar	79
Amravati	74
Bhandara	73
Dhule, Chandrapur	72
Sindhudurg	68
Parbahani	67
Akola, Jalna	65
Gadchiroli	64
Osmanabad	62
Buldhana	59
Beed	55
Nanded	53
Latur, Ratnagiri	51

Source - 'Economic Intelligence Service', Published by Centre for Monitoring Indian Economy Pvt. Ltd., November 1993.

The weightage pattern adopted to develop Relative Index of Development is as follows :

1. *Agricultural sector — 35% (per capita value of output of crops - 25% + per capita bank credit to agriculture - 10%)*
2. *Mining & manufacturing sector — 25%*
3. *Mining , manufacturing non-household & household workers per lakh of population-15%*
4. *Per capita bank credit to industry — 10%*
5. *Service sector — 40% (Per capita bank deposit - 15% + per capita bank credit to Services - 15% + literacy - 4% + urbanisation - 6%)*

Table 2.2: Comparison of the profile of the study sample on specific indicators with state and district block

	Census of India 1991				Our Study	
	Maharashtra		Igatpuri taluka	Nashik		
	Rural	Urban	Rural	Urban aggl	Rural	Urban
S.C population	11.47	10.50	7.51	13.12	9.54	29.15
S.T population	13.24	2.99	48.44	6.76	47.80	19.30
Sex ratio	972	875	977	891	993	968
(0-6 Years) sex ratio	953	934	987	931	905	988
Literacy rate	55.52	79.21	42.8	81.61	52.23	70.52
Male literacy rate	69.75	86.41	59.91	87.78	67.13	81.49
Female literacy rate	40.96	70.87	25.34	73.28	37.53	59.00
Workforce partici. rate	46.06	33.11	50.88	31.15	50.54	38.28
Male W.P rate	53.2	50.6	52.66	48.73	53.04	50.26
Female W.P rate	46.1	11.4	49.08	11.40	48.01	25.91

Source: Census of India, Series 14, Part II – B (i); Government of India; 1991

Table 2.3: Comparison of Vital Statistics for the state, district and taluka

	Igatpuri*	Nashik*	Maharashtra^		
			Total	Rural	Urban
Crude Birth Rate	29.23	24.77	25.2	27.1	22.8
Infant Mortality Rate	115.4	50.50	50.0	63.0	32.0
Crude Death Rate	8.64	8.10	7.3	9.3	4.8

** District Health Officer; Nashik District; (Nashik and Igatpuri, figures are for the year 1994)*

^ Sample Registration Survey; registrar general of India; Ministry of Home Affairs; Govt. Of India; (Maharashtra figures are for the year 1993) Source: Database on Health: CEHAT.

Foot Notes*: CBR: Crude Birth Rate., (per 1000 population), IMR: Infant Mortality Rate (per 1000 live births) CDR: Crude Death Rate, (per 1000 population)*

Table 2.4: The percentage of women who were main respondents in each age group and the probed morbidity rate in that age group

Age group of women	Probed episodes per 1000 women	Main respondents (%age)	Number of women
12 – 17 years	179	8.7	413
18 – 25 years	535	40.7	619
26 – 35 years	908	74.45	509
36 – 45 years	870	68.28	331
46 – 55 years	892	66.02	259
56 years and above	791	40.6	234
No Response	500	33.3	78
Total	**408**	**48.5**	**2443**

Table 2.5 Number of episodes reported by each individual by sex

Number of episodes	Male		Female	
	No	%	No	%
0	2516	69.3	1769	49.4
1	1036	28.5	1101	30.7
2	74	2.0	415	11.6
3	4	.1	223	6.2
4	1	.0	57	1.6
5			14	.4
6			2	.1
		3631		**3581**

Table 2.6 Number of symptoms reported for each episode by sex and use of probing

	Male		Female (without probe)		Female (with probing)	
No. of symptoms per episode	No. of Episodes	%	No. of Episodes	%	No. of Episodes	%
1 symptom	820	68.3	813	62.6	1141	70.8
2 symptoms	288	24.0	329	25.3	358	22.2
3 symptoms	92	7.7	156	12.0	112	7.0
Mean no. of symptoms	1.39	-	1.49		1.36	
Total episodes	**1200**	**100**	**1298**		**1611**	

3. Socio Economic Profile

To understand health care issues in a changing society, it is necessary to provide a perspective and backdrop against which the gathered information can be studied. Morbidity and health care seeking behaviour of a people is more fully understood against their social background. This chapter gives that overview with emphasis on the quality of life of a household and of the women living in it.

The political economy in which households are situated is complex and dynamic. So, the conventional concept of rural and urban, though necessary, is not entirely satisfactory. The interaction of these two has led to the formation of an entirely different kind of relationship. For e.g. migration (both seasonal and perennial) lent a new dimension to the concepts of economic status, occupation and poverty. This necessitates questioning many categories that are often used to understand such societies (e.g. rural / underdeveloped / traditional v\s urban / developed / modern).

The taluka and the city

In all, we interviewed members of 827 rural and 366 urban households. The rural sample was drawn entirely from rural Igatpuri taluka and the urban sample was drawn from Nashik city and suburbs. The villages and urban settlements from which they were drawn were diverse in terms of topography, culture, economy and politics.

Igatpuri taluka (rural) is spread over an area of 1006.97 sq. km. In 1991, there were 26,999 occupied residential households and a total population of 1,63,677 persons. There were 132 villages recorded in the taluka in the 1991 census. The bulk of the workforce was engaged in cultivation, while the second largest occupational category was of agricultural labourers. In actual numbers, women greatly exceeded men in this category - the numbers being 10617 and 6957 respectively.

Nashik (urban agglomeration) in which all the urban settlements were located, was spread over 321.94 sq. km. It had a population of 725,341 persons. There were 1,42,377 occupied. The majority of the main workers in this area were engaged in manufacturing, processing and services (27.9). 'Other services' like public utility services, government employees and professional services, trade or labour organisations recreational services etc accounted for a similar proportion of the main workers (27.5).

Migration was an important factor as Nashik district has 13.10 lakh migrants or 43.77 percent of the total population. Females predominate in intra-district migration while males predominate in inter district, inter state and inter national migration. The bulk of the intra-state migration in Nashik district was from rural to rural, while 17.72 percent were from rural to urban and 11.86 percent were from urban to urban. Of the total internal migrants (within Maharashtra) 29.57 percent were enumerated in the urban areas, while 70.43 were enumerated in the rural areas. Understandably, migrants from outside Maharashtra were concentrated in the urban areas (74.80 percent).

An attempt was made to make this sample as representative as possible. When compared with data on the taluka, city and the state, we find marked similarities as well as significant differences. (Table 2.2, 2.3)

As tribal / non tribal population of the village was one of the factors considered while sampling, when compared with Igatpuri taluka - rural (Census data 1991), there is a similar proportion of tribal population in the rural sample. The proportion of scheduled caste population in the sample is marginally higher. As in the urban areas, type of settlement was the criterion for sampling, there are differences in the profile of the sampled households and that of the entire city. The S.C and S.T population in our urban sample is more than twice as large, proportionally, than in the entire Nashik city (Urban aggl.) (Census, 1991). We assumed that these two

groups represent the most deprived sections of urban society, and therefore, **this study has a proportionately greater representation from the lowest socio-economic class.**

An analysis of indicators of gender inequality reveals interesting trends. (Table 2.2) The sex ratio in both rural and urban areas is higher than that recorded in the census. This may be explained by the fact that all-male households were excluded from the study. However, the sex ratio among children below seven years reveals fewer girl children in the rural households of our study but a much more equitable child sex ratio in the urban households. The rate of literacy also reveals significant differences. The rural rates of literacy are closer to the statistics obtained for the entire state, but significantly higher than those for Igatpuri taluka. Conversely, the literacy rates for the urban sample are lower than both the state and Nashik urban agglomeration. This is further indication of the fact that the urban sample has a higher representation of households of the lower socio-economic class. The fact that the female workforce participation rate in our sample is more than twice as high as that of Nashik urban agglomeration also points towards this fact.

The settlements

An important factor to be considered in the analysis of women's conditions of life is the physical environment of their households. In rural areas where villages are dispersed, physical access is an important factor in the study of health care. Thus, we decided to categorise rural households in terms of the accessibility but defining physical access was a fairly complicated exercise. Various aspects had to be taken into consideration: the existence of a road, its condition, distance to the nearest bus stop and the frequency of public and private transport available. Accessibility was measured in relation to the nearest small town/ large village, which had an in-patient public health facility. The condition of the road also varied according to the season. Thus, easily accessible villages became less so after a shower and others could get completely cut off during the monsoon. Also, villages were not a single concentrated mass of houses but dispersed settlements; accessibility varied households situated in the main village and for those located on the slopes in the wadis. (Table 3.2)

The physical organisation of rural and urban settlements is not random, but has social and political underpinnings. There is a distinct pattern in the social composition of each type of settlements. (Table 3.1). Upper caste households are concentrated in the settlements with easy access as are the scheduled caste households. All the Muslim and Christian households are in the easily accessible settlements. The Mahadev Koli households also similarly located. On the other hand, nearly one third of the Thakur and Katkari households are located in remote settlements and more than half are in settlements where access is difficult. There is a high co-relation between access and socio-economic status (explained later).

Most significant is the impact of physical access on perception of ill health and use of health care. Isolation from health facilities, educational institutions and markets reduces interaction with the 'mainstream' which is primarily responsible for increasing perception and articulation of health problems. The fact, that remote villages are usually poor add to the barriers to perception and reporting of illness. This fact - of low physical access compounded with low socio-economic status, also makes utilisation of health care difficult.

The aspect of physical isolation for women has special significance as it affects health care use not only in morbidity but also in childbirth. Ante-natal and post natal care is dispensed with due to the high monetary and time cost involved in accessing it. Reduction in mobility due to pregnancy and especially during childbirth can have very severe consequences for women's health care opportunities. Women in obstructed labour have to be carried in slings to the nearest road or health centre, a walk, which may take hours. During fieldwork in a remote village, we observed a woman being driven around the village in a bullock cart in the hope that the jerks would hasten labour. In a village with better access, this woman may have received some kind of medical attention.

In the urban sample, 66 per cent of the households lived in slums while 20 per cent lived in flats and 14 per cent in independent bungalows. In Nashik City, there was a clear demarcation of the clusters. The slums were a concentrated mass of dwellings having distinct boundaries and a great deal of homogenity both in the quality of structures and standard of living. On the other hand the households living in the bungalows though considerably above subsistence level were not all equally prosperous. There was a considerable variation in the size, condition and standard of the houses.

Of the urban sample, the scheduled caste, Muslim and Christian households were almost entirely located in the slums. The upper caste Hindu households were concentrated in buildings and bungalows. Although, in the urban areas, physical access to health services is not difficult, access may still be severely limited for slum households, where lack of education and finances impedes accessibility to health care severely.

The households in the study

There were 6.05 persons per household. The average family size in the rural and urban households varied. While it was 6.4 persons per household in the rural areas, it was 5.2 persons per household in the urban areas.

The rural households were very well established, with 87 per cent of them reporting that this was their original village (khurd gaon) or that they had been living here 'since long' (purvi paasun). In contrast, 45 per cent of the urban households had been settled in Nashik for 15 years or less. This is also reflected in the responses received to the question about the households' 'own village.' **While 67 per cent of the urban households considered themselves migrants, 92 per cent of the rural households were living in the village of their origin or were old settlers.** Usually, migrant families had few fixed assets, a poor social network and a more unstable economic condition.

Assets

Possession of assets indicates the standard of living attained by a household. While 27 per cent of the households had a television set, 33 per cent had a radio and merely 6.4 per cent owned a refrigerator. A comparison of rural and urban households reveals that 24 per cent of the rural households and 53 per cent of the urban households possessed a radio. More than 90 per cent of both rural and urban households used steel, brass or copper utensils for eating. None of the urban households reported using aluminium utensils for this purpose, while only 2 per cent of the rural households did so.

Nearly 91 per cent of urban households and 39 per cent of rural households possessed no productive assets (machinery, another house, shop, godown, implements etc.). Of the remaining 61 per cent of rural households, for 56 per cent, non-mechanised farm tools were the most valuable assets. Thus, among both rural and urban households, a very small minority owned any productive assets (except land). Urban households also had very limited access to income from land. This is an indication of the precarious position of the poorer households in the urban areas. Although, ownership of land in itself does not indicate well being, it does provide employment to women and subsidises the cost of fuel and fodder. Usually, migrant families had few fixed assets, a poor social network and a more unstable economic condition.

Occupation

The main and subsidiary occupations for each member of the household were recorded. Also included were the geographical area of work (own village, other village, city), level of organisation at the place of work (formal, informal private sector, government unit, self-employed) and the type of work (cultivator, tailor, clerk, etc). The combination of these three described the occupation of the individual. The main occupation of each individual was then re-classified into occupational categories. These categories were further ranked to indicate the

individual's relative position in the household and the community.

A particularly difficult problem of classification arose with the category of "cultivators". According to 1991 census 61.74 per cent of the rural male main workers and 58.75 per cent of the rural female main workers in Igatpuri taluka were recorded as cultivators. This study threw up figures of 57 per cent and 82 per cent respectively cultivating own land. However, this category covers a wide range of the rural population who enjoy significantly different levels of opportunities and standards of living. Thus, to disaggregate this group, it was decided to combine occupations undertaken by those whose main occupation is cultivation. In addition, on the assumption that irrigated land would signify greater prosperity and continuous availability of work, households with irrigated land were also disaggregated. Thus, three classes of cultivators: (1) Cultivators who supplemented their income with agricultural labour or casual labour. (2) Cultivators of rain fed land who had no subsidiary occupation or who practised their traditional craft or engaged in trade. (3) Cultivators of irrigated land, who had no subsidiary occupation or who practised their traditional craft or engaged in trade.

The most deprived rural workers were those who engaged in agricultural labour or migrated seasonally to the city as contract labourers. This is imperative to meet the survival needs of the family. However, a small proportion of migrants from rural areas to the city who were engaged as skilled workers or service sector workers could be assumed to have migrated in search of better opportunities.

A little over half of all the individuals were, dependants having no paid employment. (Table 3.3) Only 1.5 per cent were in the privileged category of professionals, traders and managers. The largest group of workers was in the category of informal and casual unskilled workers – wage labour – while about 10 per cent supported themselves by supplementing income from land by casual labour. Expectedly, the majority of workers in the rural areas are in cultivation. The category of professionals and self-employed in the rural areas is extremely small though the proportion of casual labourers in the male workforce is considerable.

In the urban areas, workers who own no capital and are unorganised predominate the workforce. The majority of male and female workers are engaged in unskilled labour in the informal sector. In this category, too, we find that women workers exceed men workers in real numbers — 36.4 per cent male to 64.7 per cent female. This clearly indicates that unorganised manual workers forms the base of the urban workforce. Skilled and unskilled workers in the informal sector constitute 63.2 per cent of the male workers. Thus, we find evidence of the extent of deprivation among the urban households.

The women workers enjoy even less security. In the urban areas the majority of women workers are casual or informal sector unskilled workers. Only 1.4 per cent are self employed and professionals. One third of the women are house-workers. In the rural areas, women's participation in the economy is much more visible with the majority of them engaged in the cultivation of their own land. **On combining all categories of cultivators, more women are engaged in cultivation than males. 25 per cent of the women also worked for wages in agriculture. This complements the observation that the female workers in poor rural households were the first to seek wage work in addition to cultivating their own fields.**

Socio economic status

Since the response to our inquiry on land ownership was poor, it was decided to use occupational level as an indicator of socio-economic status. As the household is an integrated unit, the socio-economic status of the family is determined by achievements of all its members. In order to evolve a standard to measure the relative status of both urban and rural households, we have used the highest occupational level attained by any member of the family as an indicator. (Table 3.4)

Half the households are situated in the lowest two

categories. About one third of the households are situated in the middle category, while a very small proportion of the households (13 per cent) are to be found in the highest category. Since land ownership is significant in ranking occupations, rural households are concentrated at the centre of the spectrum. In addition, 11 per cent of the households are found in the highest category. In comparison, we have classified 18 per cent of the urban households as belonging to this highest level. In the urban areas, we observe a greater degree of disparity, with more than one-third households belonging to the lowest level. Unlike rural households, the urban households in the second level are predominantly skilled workers in the unorganised sector who have no assets or land. Thus, the distribution of households in the rural and urban samples show marked variation.

Also, a large proportion of the urban households does not own productive resources (i.e. land, capital) and is engaged in the informal sector. In the rural areas, at least half the households have one worker engaged solely in cultivation of its own land. In spite of disaggregation, this class of cultivators shows a wide variation.

The highest class including those engaged in trade and highly qualified professionals is very minute in the rural areas. It is substantially larger in the urban areas, partly, on account of the professionals' housing colonies that we encountered. The periphery of Nashik City has become centre of rapid industrial expansion. As in any other city, these migrants have been accommodated not in the centre of the city but in newly built residential complexes in its suburban areas. Having selected such a suburban area for the sample of middle and upper income households, there was a large group of professionally qualified migrant service sector workers. An analysis of the distribution of the household across 'class' shows the high degree of polarisation in the urban areas in comparison with the rural scenario. As the categorisation of 'status' places great emphasis on ownership of the means of production (in this case, mainly land), more households are concentrated towards the centre of the spectrum.

Poverty

Poverty, in the present context, must be seen in two dimensions: scarcity of resources/income and the dependence on the market. Although the upper class in both the urban and rural samples is small, the majority of the rural households are relatively better placed although the landless in rural areas are distinctly the most deprived. Wage-workers, who form the bulk of the urban workforce, are dispersed across a wide range. 136 of the 366 urban households (37 per cent) were settled in slums and had either no earners or all their workers were employed as unskilled informal sector or casual workers.

Urban households are concentrated in the two lowest classes. In spite of greater availability of employment, urban households must use cash to purchase all the necessities required for survival. Although one accepts that the rural population no longer has any unlimited access to 'free goods', fuel, fodder and water are still not commodities to be purchased routinely from the market. However, for the poorer households in the urban slums, the purchase of these necessities constitutes an important part of their cash expenditure. In the context of health care utilisation, both the need and availability of cash income are very significant factors. Thus, the predicament of poor urban households can be easily imagined.

The women in the study

Position in the family

There were 3581 women in the sample. On average, there were three women members in a household. While 34 per cent of the women were daughters of the household head, 29 per cent were wives. The other significant groups were daughters-in-law (13 per cent) and grand-daughters (11 per cent). Thus, almost all the women belonged to the immediate or extended family of the head of the household. (Table 3.5)

Marital status

An important aspect to consider in a study of

women's health is marital status. Combined with age, it is a fair indicator of the pattern of life of women (Table 3.6). Nearly 45 per cent of all women were married and cohabiting. Another 1.8 per cent of the women lived in households with their co-wives. A substantial 9.3 per cent were once-married single women (only 1.4 per cent of the men were in this category). This is an indication of the grossly unequal opportunities for re-marriage offered to men and women. There were also marked differences in the marital status of women in the different age groups. There were no married women below the age of 12 years. However, 17 per cent of the girls between 12 and 17 years were already married. By the age of 25, more than four-fifths of the women were married (82.7 per cent). Marriage of 26 women (4.2 per cent) had ended due to widowhood or separation. Among the older women, there was a consistent increase in the proportion of widows with more than half the women above 55 years being widows.

Marriage was an imperative for all women; no woman above 35 years recorded as never-married. An analysis of the marital status indicates that marriage for most women takes place between 18 and 25 years, while widowhood is very common among the aged women. When we consider that the sex ratio in all age groups is adverse, the only explanation for the high proportion of widows is the vast gap in the ages of husbands and wives. The mean age for currently married women was 33 years and for men, it was 39 years. Thus, the mean age difference between spouses is 6 years.

Though 63 women – small in number — were living in the households with other wife/s of their husbands, the existence of such households indicates a high degree of gender inequality. An analysis of the marital status and childlessness for women above 25 years shows that while 14 per cent of the currently married women had no living children, 23 per cent of the separated and divorced women and 35 per cent of the 'one of two/three wives' were childless. **This indicates very clearly the strong co-relation between bigamy, the desertion of women and childlessness.**

Number of living children

Though there is little information on the reproductive history of women, we have recorded the number of living children for each married woman. (Table 3.8) It gives a fair estimate of the burden of childbearing that they have had to bear. **For all the women in the sample, it was an average of 2.81 children per woman.** However there was a steady decline in the number of children per woman in the younger age group. While women above 56 years had 3.85 living children each, it was 3.14 for women between 26 and 35 years. Older urban women had more children than their rural counterparts. In women above 45 years, there was a marginal increase in the average number of children per woman. However, the most significant factor is the steady reduction in the number of children in the younger age groups. Assuming there has been an improvement in child survival, it can be concluded that younger women are bearing relatively even fewer children than older women.

Composition of the households

Expectedly, there was a difference in urban and rural household composition. A nuclear family was defined as comprising spouse and children of the head of household. A joint family was defined as a family that had members who shared a relationship to the head other than wife and child.

The nuclear male-headed family predominated in the urban sample while the joint and nuclear male-headed family was almost equally common in the rural sample (Table 3.7). However, there was a distinct difference in the female-headed rural and urban households. While in the former, the joint family was more common, the nuclear family predominated the urban sample. 67. 8 percent of the rural women lived in joint households, while 46.7 percent of the urban women lived in joint households. While 12.2 percent of the women lived in female headed rural households, 11.3 percent of the urban women lived in female-headed households.

69.3 percent of the nuclear households had only one

woman above 12 years of age. Conversely, 47.4 percent of the joint households had three or more women above 12 years. The number of adolescent and adult women in the household played an important role in determining the distribution of household work. The fewer the number of women, the greater was the burden of housework. Understandably, 78.4 of the women above 12 years in single woman households lived with families of upto 5 members. While the size of the family was an important factor in deciding the quantum of work, all households require a certain minimum of labour to function. Thus, single woman households, whether large or small, placed a great burden of housework on women. Also, women in single woman households are more likely to be earners.

The size of the family and the number of women in the household have been used as variables of analysis in this report in order to understand the intra-household distribution of work and opportunity for health care among women. While such analysis is incomplete without taking into account earning status and distribution of power in the household, it at least allowed us to integrate the internal and external world of the household in order to study women's health care situation more holistically.

Respondents

Due the modifications we made in the methodology, the discussion on respondents gains additional significance. The study assumed that women would not report certain categories of illness without probing. Hence, the use of the probe list. However, probing is unlikely to be equally effective with women when they are answering for themselves and for other women in the family. In addition to that, the profile of the respondents is important in order to understand the nature of the information received. The respondent represents the household in this study.

In the rural households, relatively more households had multiple respondents (Table 3.9). The presence of male respondents was also more frequent than in the urban. As large joint families were more common in the rural area, more than one woman participated in the interview. This seems to suggest that information, at least, on the health of other women in the households would be reported. In the urban households, typically, one adult woman in each household responded to the interview.

One of the respondents was identified as the main respondent. In only three cases in rural sample and four cases in the urban sample was this respondent male. In both cases, the main respondent was most likely to be the head or the spouse of the head of the household (Table 3.9). However, in the rural households, others, including the sisters/daughters-in-law formed a sizeable 21 per cent of the respondents.

An analysis of the age group in which these respondents were to be found indicates that the average age of the respondents was 36 years (Table 3.10). The average age of the rural main respondent was 36 years and the urban main respondent was 34 years. 39 per cent of the urban female members were respondents while 31 per cent of the rural female members were respondents. Among women of between 25 years and 55 years in both the rural and urban samples, the likelihood of that woman being the main respondent was extremely high. This becomes a significant fact in the context of the methodology used in our study. The use of the probe list, the objective of which was to record unperceived morbidity, was most likely to be successful when answered to by the woman herself.

The marital status of the main respondents indicates the strong bias towards women who are currently married and cohabiting (Table 3.9). Single ever-married women were proportionately represented among the respondents but never-married women were very poorly represented. Most of them were girl children and adolescents. However, the fact that very few girls between 12 and 17 years were respondents, although the probe list applied to them, may have a bearing on the reporting of additional morbidity in this age group.

Conclusions

There was a wide variation in the socio-economic status of households in both the rural and urban samples. A large proportion of the households, in both samples, had no assets or access to land. The poorest households were in a relatively greater proportion in the urban sample which led to greater disparity in the sample. A large majority of the workers were unskilled and worked in the casual or informal sector. Women were almost invariably employed in this sector. **Women were less likely to be employed and have a lower occupational status than men.** This is seen in the fact that they were more likely to be employed as agricultural cultivators or cultivator-labourers than men in the rural sample and in the informal and casual sector in the urban sample.

Within households, women were dependants, with only 13 per cent of the households headed by women. They were mostly married between the ages of 18 and 25 years though a substantial number married before 18 years. Childlessness among women living with co-wives and deserted women was high, indicating the importance place on the bearing of children to ensure continued familial support. **The 25-45 year old ever-married women predominate among the respondents. Thus, it is their health problems which, are highlighted greatly in the study.**

Table 3.1 The location and community/caste of rural and urban households

Rural							
	Easy access		Difficult access		Remote Access		Total
	No.	%	No.	%	No.	%	No.
Upper castes	97	66.0	37	25.2	13	8.8	147
Middle castes	49	28.5	116	67.4	7	4.1	172
Scheduled castes	51	57.3	37	41.6	1	1.1	89
Mahadev Kolis	112	69.1	42	25.9	8	4.9	162
Thakur / Katkari tribes	30	16.3	96	52.2	58	31.5	184
Other scheduled tribes	28	53.8	24	46.2	-	-	52
Muslims, Christians	21	100.0	-	-	-	-	21
Total	388	46.9	352	42.6	87	10.5	827

Urban					
	Slum		Non slum		Total
	No.	%	No.	%	No.
Upper castes	14	17.9	64	82.1	78
Middle castes	26	44.1	33	55.9	59
Scheduled castes	81	83.5	16	16.5	97
Scheduled tribes	65	91.5	6	8.5	71
Muslim, Christian, Other	55	90.2	6	9.8	61
Total	241	65.8	125	34.2	366

Table 3.2 Distribution of rural households according to access

Village and description	Easy access	Difficult access	Remote
Wadi warhe, village located at a distance of less than 1 km from the Mumbai-Nashik highway. Connected to Igatpuri and Nashik by frequent state transport and corporation buses	102		
Dhamangaon, this village is located on the busy road connecting Bhagur and Ghoti. Frequent buses and private vehicles.	94		
Kaluste Gaothan on flat land with bus stop and private jeeps starting every half hour to Ghoti, the nearest large village, having rural Wadis on slopes and across streams, no bus stop and no motorable road	59	37	
Pimpri Sado, located at a distance of 7 kms from Igatpuri, connected to town by ST buses, rickshaws and other private vehicles. Wadis located at a distance from main village, no bus stop and no motorable road.	52	28	
Take Harsha, located close to road to Vaitarna and on the route to Trimbak. Frequent buses and private vehicles ply on the road. Wadis located away from main village, some have no bus stop.	43	30	
Dahalewadi, located close to road to Vaitarna and on the route to Trimbak. Frequent buses and private vehicles ply on the road. Wadi located away from main village.	37	1	
Lahamge wadi, no bus stop in village. Located close to Wadi Warhe	1	17	
Kanadwadi bus stop three kilometres from village and the road is in bad condition and distance from Igatpuri 25 kms			9
Manwede Bus route bisected by river Darna and can be crossed only in summer. The rest of the year, vehicles required to take a long detour to Igatpuri		44	
Jamunde located on a hill slope requiring a one and half - hour climb. Very rocky motorable road, unusable except in summer months.			27
Fangul Gavhan, bus stop located in neighbouring village, however narrow motorable road present.		67	
Shirsete, bus stop present, however road intersected by stream and in bad condition.		60	
Kurungwadi, Located very high on hill slope requiring three hour climb. Extremely rocky road usuable only in summer. No bus stop. Road to nearest village intersected by river.			26
Bharvir Bk, resettled village with homesteads located far from the main road. The reservoir of the dam neccesitates vehicles to take a circuitous route. However, private jeeps to Bhagur ply regularly.			53
Bhandardarawadi, located on the same road as Bharvir Bk. Further ahead. However, the wadis located at considerable distance from the main village, no bus stop and very bad road.		15	25
Total	**388**	**352**	**87**

Table 3.3 Occupational status of all earners and all individuals in rural and urban households by sex

Occupation of Employed Persons	Rural				Urban			
	Male		Female		Male		Female	
	No.	%	No.	%	No.	%	No.	%
Professionals, Traders, Managers	31	2.2	1	0.1	66	13.5	13	5.1
Formal Sect' Skilled & Service Sector Wrkrs	49	3.5	6	0.5	74	15.1	21	8.2
Informal Sector Skilled & Service Sector Wrkrs	101	7.2	18	1.4	131	26.8	27	10.6
Informal & Casual Unskilled Workers	378	26.8	233	18.3	178	36.4	165	64.7
Sole Cultivators (Rain Fed)	406	28.8	457	36	8	1.6	8	3.1
Any Others	51	3.6	24	2.9	27	5.5	21	7.8
Sole Cultivators (Irrigated Land)	101	7.2	93	7.3	1	0.2		
Cultivator Labourers	295	20.9	438	34.5	4	0.8		
Total	**1412**	100	**1270**	100	**489**	100	**255**	100
Non earners	1247	46.8	1008	38.1	478	49.3	381	40.6
House-workers	3	0.1	365	13.8	2	0.2	302	32.2
Employed (earners)	1412	53.0	1270	48.1	489	50.5	255	27.2
	2662	100	**2643**	100	**969**	100	**938**	100

Table 3.4 Socio-economic status of the household in rural and urban areas

Highest Level Of Occupation Attained by any member of Household	Rural		Urban		Total	
	No.	%	No.	%	No.	%
Non workers, casual labourers and agricultural labourers	144	17.4	136	37.2	280	23.5
Informal sector Skilled labourers and artisans, cultivator-labourers	244	29.5	99	27.0	343	28.8
Formal sect. skilled and service sector workers, sole cultivators of rain fed land	347	42.0	65	17.8	412	34.5
Professionals, managers, sole cultivators of irrigated land	92	11.1	66	18.0	158	13.2
Total	827	100	366	100	1193	100

Table 3.5 Relationship of women to head of household

Relationship to head of household	Number	Percent
Self	155	4.3
Parent	143	4.0
Sibling	36	1.0
Spouse	1039	29.0
Child	1198	33.5
Grandchild	393	11.0
Parent in law	26	.7
Any other relative	82	2.3
Not related	1	.0
Daughter in law	461	12.9
Sibling in law	22	.6
Niece	15	.4
Grandparent	5	.1
Aunt	2	.1
Co wife	3	.1
Total	**3581**	**100.0**

Table 3.6. Marital status of women according to age group (in years)

	Upto4	5 - 11	12 - 17	18 - 25	26 - 35	36 - 45	46 - 55	Above 56	No response	Total
Currently married & cohabiting	-	-	67 16.2	511 82.7	453 89.0	260 78.5	176 68.0	94 40.2	58 74.4	1619 45.2
Never married	491 100.0	647 100.0	343 83.1	76 12.3	2 0.4	-	-	-	5 6.4	1564 43.7
Widowed	-	-	-	13 2.1	19 3.7	39 11.8	68 26.3	136 58.1	12 15.4	287 8.0
Separated/divorced/deserted	-	-	3 0.7	13 2.1	16 3.1	10 3.0	3 1.2	2 0.9	-	47 1.3
One of two/ three wives	-	-	-	5 0.8	19 3.7	22 6.6	12 4.6	2 0.9	3 3.8	63 1.8

Table 3.7. The type of family in the rural and urban sample

Type of family	Rural		Urban	
	Number	Percent	Number	Percent
Nuclear male headed	339	41.0	211	57.7
Nuclear female headed	30	3.6	22	6.0
Joint male headed	375	45.3	113	30.9
Joint female headed	83	10.0	20	5.5
Total	**827**	**100.0**	**366**	**100.0**

Table 3.8 Average number of living children per ever married woman in each age group

Age group	Total	Rural	Urban
12 – 17 years	.26	.28	.11
18 – 25 years	1.62	1.61	1.66
26 – 35 years	3.14	3.25	2.91
36 – 45 years	3.52	3.65	3.15
46 – 55 years	3.45	3.40	3.59
56 years & above	3.85	3.70	4.27
No response	2.96	2.86	5.33
Total	2.81	2.79	2.87

Table 3.9 Profile of the respondents

The gender of respondents in rural and urban households			
Gender of the respondents	**Rural**	**Urban**	**Total**
One woman	711 (86.0)	344 (94.0)	1055 (88.4)
Woman and man	55 (6.7)	8 (2.2)	63 (5.3)
More than one woman	61 (7.4)	14 (3.8)	75 (6.3)
Total	**827**	**366**	**1193**
Main respondent's relationship to head of the household			
	Rural	**Urban**	**Total**
Self	81 (9.8)	34 (9.3)	115 (9.6)
Spouse	570 (69.0)	272 (74.3)	842 (70.6)
Others	175 (21.2)	60 (16.4)	235 (19.8)
Total	826 (100)	366 (100)	1192 (100)
Note: One rural respondent did not belong to the household sampled.			
Marital Status of main respondent			
	Rural	**Urban**	**Total**
Never married	11 (1.3)	12 (3.3)	23 (1.9)
Currently married and cohabiting	708 (85.7)	310 (84.9)	1018 (85.5)
Widowed, separated, deserted, divorced	107 (13.0)	43 (11.8)	150 (12.6)
Total	826	366	1192
Note: Number of missing cases: 1			

Table 3.10: The proportion of women who were main respondents in each age group in comparison to their proportion in the total sample population.

	Main respondents			Total women in age group		
Age group	Rural	Urban	Total	Rural	Urban	Total
Up to 4 years				364 (14.2)	127 (13.6)	491 (14.0)
5-11 years				486 (18.9)	161 (17.2)	647 (18.5)
12-17 years	26 (8.3)	10 (10.0)	36	313 (12.2)	100 (10.7)	413 (11.8)
18-25 years	167 (37.4)	85 (49.1)	252	446 (17.4)	173 (18.5)	619 (17.7)
26-35 years	248 (70.5)	131 (83.4)	379	352 (13.7)	157 (16.8)	509 (14.5)
36-45 years	166 (67.2)	60 (71.4)	226	247 (9.6)	84 (9.0)	331 (9.4)
46-55 years	121 (65.4)	50 (67.6)	171	185 (7.2)	74 (7.9)	259 (7.4)
56 years & above	70 (40.0)	25 (42.4)	95	175 (6.8)	59 (6.3)	264 (6.7)
Sub Total	798 (31.1)	361 (38.6)	1159	2568 (100,0)	935 (100.0)	3503 (100.0)
No response	28	5	33	75	3	
Total	826	366	1192	2643	938	

Note: % in column 2 and 3 indicates the percentage of women in that age/ rural-urban group who were main respondents. % in column 5,6 and 7 are column percentages

Number of missing cases: 1

4. Morbidity

The socio-cultural dimensions of health

Morbidity is understood in this study as a social state, not merely a biological one. The perception of illness reflects not merely the health problems of individuals but also their understanding of their own bodies and their relationship to the living environment. It is not merely the changing disease patterns that lend dynamism to the concept of morbidity, but a host of other social factors as well. Thus, analysing the gathered data meant understanding it in the social context in which information was received.

The relationship between the existence of disease and its perception is complex. A study of reported morbidity is not the study of diseases, but a study of ill health. The correspondence between the actual classifiable disease which can be observed, the manner in which it is perceived as illness and the articulation of that experience can vary considerably. **For morbidity to be recorded, it has to be perceived and reported.** This may not happen due to various socio-cultural and political reasons. Social barriers of caste and class and differences in language and culture between interviewer and respondent may affect the reporting of morbidity.

For instance, the manner of the interviewer may become prejudiced, prompting the respondent to either withhold information or give a tailored response. In other cases, certain words may have a specific connotation for the respondent, which the interviewer is not able to understand. Or, there may be no specific words in that language to describe the experience of the respondent. Certain kinds of illness, such as sexually transmitted diseases or reproductive tract infections have cultural associations, which may prevent their being reported in a survey. Certain problems such as aches and pains are so widespread that they are not perceived as illness and are therefore not reported. There is also a possibility of a feeling of 'not being well' in the absence of disease, which also gets recorded as morbidity. Thus there is some element of subjectivity in the recording of perceived morbidity.

However, the importance of reported morbidity study lies in the fact it is an economical method to gauge the extent of ill health in a community. Also, perceived morbidity uncovers other social dimensions of health. It has direct implications for estimating the need and demand for health care and the extent of expenditure that is or would be incurred. Hence, while perceived morbidity is not a completely accurate measure of the 'burden of disease' in a community, it has significant importance in understanding the social processes underlying health and health care in a given community.

Background

Although data on mortality does not give much insight into the pattern of morbidity existing in the population, it provides us with some information on health problems. The survey of the causes of death for rural Nashik (DHO, Nashik district; 1995) shows that respiratory diseases are the chief cause of death for both males and females. 27.8 per cent of the total 772 deaths surveyed were due to respiratory diseases.

Blood and circulatory disorders were the second most important cause of death accounting for 18.4 per cent of the surveyed deaths. Accidental deaths and suicide accounted for 10.5 per cent of the total deaths. While the deaths of infants from birth complications and infections accounted for 11.5 per cent of the total deaths. Deaths due to gastrointestinal diseases accounted for 6.3 per cent of the total deaths. There are only marginal differences in the causes of deaths for males and females. We find that 1.2 per cent of the female deaths are maternal deaths. Of the 772 deaths, 12.69 per cent of the deaths are of infants below one year of age, while 18.65 per cent of the deaths occurred among children below five years. 18.10 per cent of the female deaths were of women between 15 and 45 years.

In general, we find that respiratory illnesses and circulatory disorders are important causes of death

in rural Nashik. Gastrointestinal diseases do not account for a very large proportion of deaths, while accidental deaths and suicide constitute a significant proportion of total deaths.

Extent of morbidity

In this study, we recorded a total [monthly] morbidity rate of 570 episodes per 1000 persons. (Table 4.1). Expectedly, due to the methodology used, **there is a vast difference between the morbidity rates for men and women. While for men it is 330, for women it is 812.** There is only a marginal difference between the total (both sexes combined) rural and urban rates, which are 569 and 571 respectively.

While men in the urban areas reported a lower rate of morbidity than their rural counterparts, the reverse is true for women. Men in the rural sample reported a morbidity rate of 346 per thousand; their urban counterparts had a rate of 285. For women the rates were 793 for rural and 866 for urban sample. A significant factor contributing to these dramatically high rates of morbidity is the reporting of multiple episodes, largely, by women. While 2 per cent of the men reported more than one episode during the recall period, a substantial 20 per cent of the women did so. While 11.6 per cent of the women reported two episodes of illness, 8.4 per cent of the women reported three or more episodes.

Probing was responsible largely for the reporting of multiple episodes among women. For instance, a woman may report an acute episode of malaria before probing. After probing, an episode of work related chronic back-pain could be added to it. **As actively probing for illness resulted in the massive rise in morbidity, it may be incorrect to gauge the quantum of illness from the morbidity rate alone. However, multiple episodes are certainly an indicator of the complexity of women's health problems.**

An analysis of the *number of persons ill* also gives evidence to the high morbidity prevalence in the sample. 406 out of every 1000 persons in the sample reported at least one episode of illness in the previous month. The rural-urban difference was considerable, with the figure for the rural area being 419 persons and the urban areas 369 persons. The gender difference was also significant with 307 men and 506 women out of 1000 reporting an illness. While 326 rural men reported an illness, 254 in the urban sample reported an illness. For rural and urban women, the numbers were only marginally different, being 512 and 487 respectively.

With regard to the type of morbidity (Table 4.2), fevers and respiratory problems constitute the largest categories of illness in the total population. Reproductive health problems, aches and pains follow them. However, as probing for illness was restricted to women, it would be incorrect to compare morbidity data for males and females. Probing was designed to elicit more information on specific types of illness; hence, a gender-specific analysis of type of morbidity would be more meaningful.

Male morbidity

The use of exclusively women interviewers and women respondents was an important part of the methodology of this study. However, there is a very strong possibility that this method affected the reporting of morbidity for men. The morbidity rate obtained for men was 330, while that for women (prior to probing) was 362, a difference of 9.6 per cent. This marginal difference in male and female morbidity has been observed in the previous studies. Also, in spite of interviewing only women respondents, the morbidity rate obtained for men in this study is considerably higher than that reported in any of the previous studies.

Morbidity is the highest among men above the age of 45 years (373) (Table 4.3) while among young men between 18 years and 45 years it is the lowest at 292 episodes per 1000. Morbidity among boys below 18 years is higher being 350 episodes per 1000. Thus, the characteristic J shaped curve is also to be found in this study for morbidity among men.

Among men, acute infections constituted a large proportion of the morbidity reported (Table 4.4). Of them, unclassified 'fevers' constitutes the largest component accounting for 37.5 per cent of all episodes. Respiratory illness was the second most important category with 27.3 per cent of all the episodes. G.I.T problems were relatively less significant accounting for 9.1 of the illness episodes. General aches and pains constituted 7.1 per cent of male health problems.

The most significant difference in the type of morbidity among rural as compared to urban males is the substitution of fevers by respiratory problems as the single largest category of illness. This clearly indicates the co-relation between morbidity and the environment. Igatpuri taluka has a high prevalence of malaria that is indicated by the overwhelming numbers of fever episodes reported there. The upsurge of respiratory problems of rapidly developing urban centres has been well documented. The pattern of morbidity recorded in the Nashik city's male population confirms that trend.

The fact that acute infections dominated reported male morbidity is confirmed by the fact that more than half of the episodes reported among men were of seven days duration or less (Table 4.4). While 77 per cent of the episodes in the rural areas lasted for less than a month, only 70 per cent of the urban episodes had a similar duration. 11 per cent of the rural episodes and 17 per cent of the urban episodes were reported to be associated with an illness having duration of one year or more. This suggests that urban men suffer from or, at least, report more chronic health problems.

This study also attempted to record the perceived cause of illness. The perception of illness is structured by many external factors. The stated cause of illness is a key to understanding not merely the nature of the illness, but also the social context in which the individual experiences illness. In 71.08 per cent of the episodes (853 out of 1200), a reason was stated for the illness. Upto two reasons were recorded for each episode of illness. The reasons stated for male morbidity are also in keeping with the type of illness reported by them. More than 60 per cent of the reasons reported relate to environmental factors (food, water, weather etc.) and to the occurrence of an epidemic. Work and fatigue, as causes of illness constitute the other major category making up 11.4 per cent of the stated reasons. Remarkably only 3 per cent of the reasons relate to general debility (weakness, old age). Injury and trauma are the other significant reasons stated for illness (7.3 per cent)

The reporting of morbidity among men is done entirely by women. It is possible that the morbidity especially of young men who stay out of the house for the most part of the day are missed out. Women also reported morbidity for all children. **Women have reported higher morbidity for young boys below five years than for girls of the same age; morbidity rates being 431 and 372 respectively. This finding is explained by the fact that more attention is paid to boys in their childhood. Surprisingly, this gender difference is not to be found in the older age groups.** For children between 6 and 11 years, the morbidity is reported to be equally high among boys and girls, the morbidity rates being 350 and 349 respectively. The rise in women morbidity is consistent across all the age groups till old age. However, no comparable trend is observed among men. In general, we find that morbidity rate is high for young boys and it declines till the age group of 26-35 years. After that, the rate increases gradually. It is possible that due to the fact the all reporting of male morbidity is by proxy, the absence of consistent trend may be due to problems of reporting. Therefore it is necessary to interpret all the findings about male morbidity cautiously.

Morbidity among women

The quantum of morbidity recorded among women was unprecedented. 2909 episodes were recorded for 3581 women. (Table 4.5) Half the women (1812 women, 50.06 per cent) in the entire sample reported being ill in the month prior to the interview Thus, 812 episodes of illness were reported per 1000 women

in the same period. **The morbidity rate among women reported without probing was 362 episodes per 1000, this rose to 812 episodes per 1000 after probing.** Thus, the morbidity rate for women increased by 124 per cent. Likewise, we find that the number of women reporting an illness before probing was 339 per 1000, while, after probing, 506 women in every 1000 reported having an illness in the past month.

Expectedly, there was a wide variation in the quantum and pattern of morbidity among women. Complex networks of factors determine health status. In order to understand the social context in which women live, we have studied the *position of the woman's household* and her *position in the household.* Morbidity, as well as other aspects of health care must be related to both these factors.

Geography

The difference in the quantum of morbidity reported by rural and urban women was noteworthy (Table 4.5). While the morbidity prevalence rate for the rural women was 793 (2096 episodes for 2643 women), for the urban women, it was 866 (813 episodes for 938 women). However, the pattern was reversed for the number of women ill. Proportionately more rural women (512 per 1000) were ill during the recall period than urban women (487 per 1000). **This indicates that a higher proportion of urban women reported multiple episodes of illness than rural women.** The reason the reporting of more multiple episodes among urban women could be that the urban women were most likely to be responding for themselves. Probing was relatively more effective among urban women. It has also been noted that the level of awareness about health is higher in the urban areas, leading to higher reporting of morbidity. It is also important to remember that the urban sample has a very high proportion of slum households surviving in poor and unhealthy surroundings, which may have resulted in finding high morbidity among women in urban households. The higher reporting of multiple episodes among urban women may in fact be a combination of all these different factors.

Duration of settlement

In general, the duration of settlement was correlated with morbidity. **While old/original settlers reported a morbidity of 789 episodes per 1000 women, migrant women had a morbidity rate of 866 episodes.** This difference is distinct in the rural areas, where the migrant women have a morbidity rate of 973 in comparison to the total rural morbidity rate of 793. The ill persons' rate for migrant women is also higher than that for settled women. As explored in the earlier chapter, the rural households, in general, were relatively well established. Hence, the difference between the migrants and the old settlers was quite striking.

Migrant families in rural areas were almost invariably the poorest in the village. These women were almost always land-less agricultural labourers. Thus, it is not surprising to find that they have reported higher levels of morbidity. In comparison, the migrant urban women had a varied socio-economic profile. They actually outnumber the original settlers. Also, they could belong to families of varied socio-economic class. Also, they do not differ so significantly in the quantum of morbidity reported. However, as may be seen in the following chapters, they are less likely to receive health care for their problems.

Socio-economic class

As explained in the section of methodology, it was not possible to record accurate information on income and assets. However, the highest occupational level in the household was used as an approximate measure of socio-economic status. **Among rural households, there is no consistent relationship between socio-economic status and morbidity**. Among the lower three classes, the morbidity rate declines with rise in socio-economic status. However, the highest class has reported higher morbidity than the preceding class. The noteworthy finding here is that the women of the lowest class have reported the highest morbidity. For the households of land-less labourers and unskilled workers, we find that the morbidity rate is 951, while 586 women out of every 1000 in this class have reported an illness.

Urban areas show a highly consistent inverse co-relation of the morbidity rate with socio-economic class. However, *the number of women reporting an illness* in every class is not very highly co-related. The difference in the morbidity rates of women of different socio-economic classes, in both rural and urban households is much greater than the difference in the number of women ill for each class. This is an indicator of the greater impact of probing for poor women. Among the poorest rural women, the increase in the morbidity rate after probing is 15 per cent more than that for all women. While for the poorest urban women, the increase is 36 per cent. Thus, the use of probing reveals a greater burden of unreported morbidity among poor women. In general, **the dramatically high morbidity rate for women in the poorest households is a telling indicator of the effect of poverty on women's health.**

Caste/community

In rural households, where caste/community is still an accurate indicator of socio-economic status, the scheduled caste (880) and minority community (1009) women have higher rates of morbidity than upper caste (803). However, all these groups have a higher morbidity than tribal women (745). This finding is inconsistent with our finding that poorest women have highest morbidity. If we assume that the burden of illness must be highest among the poorest women, the morbidity rate among tribal women should have been among the highest. However, we find that the reverse is true. In fact, that the most deprived communities even among the tribal (Thakurs and Katkaris) have the lowest morbidity rates among all rural women.

However, the effectiveness of probing among tribal women was low. There is a marked difference in the socio-political conditions of tribal villages and non-tribal villages. Culturally, as well as economically, tribal villages are marginalised. Health facilities are absent, schools are non-functional and there is very peripheral contact with the market and media. The differences in culture and language as well as lack of opportunity to access health care may lead to low consciousness of health problems and, thus, low perception of morbidity. The fact that the process of probing did not remedy this imbalance cautions us about the limitations of this methodology.

Access

The classification of rural households according to 'access' shows that higher morbidity was reported by 'easy access' households (813) and the lowest morbidity by remote households (700).

It was observed in the previous chapter that the caste/community groups tended to concentrate into settlements (villages/wadis). The two tribes mentioned above were concentrated mainly in the remote village/wadis. There is a similar pattern of morbidity in the analysis with 'access' as with caste/community. Those in the 'remote' settlements have lower morbidity rates than the other women. Here, too, the morbidity rates vary significantly more than the rate of persons ill. This is further evidence to suggest that the entire range of illness among the women in the 'remote' settlements have not been captured by our study.

It is widely accepted that higher perceived morbidity does not necessarily translate into more ill health. It is important for women to be able to articulate health problems for a study of perceived morbidity. The multiplicity of illness reported is an indicator of the ability to articulate health information. If we accept that perception is deeply influenced by access to services, a pattern emerges. As will be seen in the following chapter, most of the illness in the 'remote' settlements was not treated. Apart from health services, access is also vital in determining the level of awareness about health problems through the media, contact with modern market systems, a complex social structure and integration with 'mainstream life'. When we consider that the minority community households were situated entirely in the 'easy access' settlements and the Thakurs and Katkaris largely in the 'remote' settlements, the differences in morbidity reporting according to caste/community status appear logical.

A combination of cultural factors and social access are necessary to understand the pattern of morbidity. It has often been argued that perceived morbidity as a concept is biased against deprived and marginalised groups, as they are less able to articulate their health problems. Apparently, it appears so in this study, too. However, the information on health care utilisation makes clear the links between deprivation and morbidity. When we observe that women in these communities have the least access to health care even for the low level of morbidity reported, it can only mean that actual ill health among them must be much more widespread than is reflected in our study.

Comparing slum and non-slum households in the urban areas, we find a drastic difference in the morbidity reported by women. **The morbidity reported by women in non-slum households is significantly lower than the morbidity reported by women in slum households.** While physical access may not differ significantly, the social and economic condition of the two groups of women is vastly different. This reflects itself in the higher reporting of morbidity for women whose households are living in poverty, and whose work burden is tremendously high owing to the deterioration of the living environment as well and the need to engage in poorly paid wage work together with hard domestic labour.

Composition of household

If only the quantum of morbidity is considered, interesting trends emerge in relation to the composition of the household (Table 4.6). In both rural as urban households, there is a negative relationship between the size of the households and morbidity. The morbidity rate for women in families having five members or less is 991, while for women in families of more than 15 members have a morbidity rate of 450. With increase in family size, proxy reporting increases resulting in a lower reporting of morbidity for family members other than the respondent. Also, the number of women above 11 years in the household is co-related to the morbidity rate reported by women in those households. In households having only one woman, the female morbidity rate is 1016, while when there are 3 or more women, the morbidity rate is 672.

The co-relation between the burden of housework and illness is best understood when we consider the family size and number of women together. The comparison of single woman households is most reliable, since the women in all these households responded for themselves. When there is only one woman in a household of five or less members, the morbidity rate of such women 1500, while the ill person's rate is 765. However, when there is only one woman in a household of 6 to 10 members, the morbidity rate is 1727, while the ill person's rate is 828. Similarly, for a given household size, the morbidity rate for women above 12 years declines consistently with increase in the number of women. Thus, for households with five to ten members, when there is only one woman above twelve years, the ill persons rate for these women is 828, while it 701, when there are two women and 546 when there are 3 or more women.

Though no conclusive observation can be made from these findings, it would be interesting to explore further the link between household labour and women's health. It is well known that male members of the household do not share responsibility for housework. Thus, the women must distribute the load of housework among themselves. The presence of more women is likely to lead to greater distribution of work and, thus, less physical exhaustion. However, even in such a situation there is unlikely to be equal distribution of work. The relationship of work to family structure must be explored more deeply for such an analysis. The relationship of work itself with ill health needs an exploration much deeper than was possible within the scope of this study.

Apart from the factors that influence the household, women are also affected by power structures and relationships within households. Thus, the individual profile of the woman also determines health status to a large extent.

Life stage

The most significant individual characteristic affecting women's health appears to be their life stage (Table 4.7). In contrast with men, among whom we find that morbidity is highest in childhood and old age with an intervening period of low morbidity, **among women morbidity continues to increase with age.** For all women above 18 years in rural and urban areas, more than 1000 episodes for every 1000 women were recorded. Also 65 to 70 per cent of the women in these age groups report illness. Most household studies, which have reported age-wise information on morbidity, have shown a similar trend. Adult morbidity exceeds child morbidity among women. Although there is a constant increase, we see a sharp rise in the morbidity rates after the age of 25 years, an age when childbearing is continuing or has even been completed. **There seems to be a definite co-relation between childbearing and morbidity.**

However, it is important to note that morbidity does not decline for women with any stage in life. Post-menopausal women have a larger number of health problems than women in the reproductive age group. This further indicates the incremental nature of women's health problems. It is widely argued that childhood illness and neglect contributes much to adult women's health problems. Similarly, high morbidity in youth is followed by high morbidity in old age. Culturally, as well as politically, older women's health problems have been ignored, as they are no longer producing children. However, it must be noted that not only are ageing women vulnerable to degenerative diseases, but they must also continue to endure the consequences of neglect and ill health during the reproductive years.

Marital status

The analysis shows a highly significant co-relation of morbidity with marital status of women as well. Never married women have the lowest rates of morbidity (379). Ever married women have much higher rates of morbidity. Currently married women have a morbidity rate of 1141 episodes per thousand women. The highest rates of morbidity are to be found among ever-married single women (1182).

While only 344 never married women out of a thousand reported an illness, 685 widowed, divorced, deserted and separated women out of 1000 reported illness. The difference in the average age and social situation of these two groups of women play a significant role in determining their health. It would be interesting to note whether certain social factors such as lack of support and rejection in itself can articulate itself as high morbidity.

Number of living children

The number of children borne by a woman has significance for morbidity (Table4.8). Though complete reproductive history of all women was not available, **there is a definite relationship between the number of living children and morbidity. The morbidity rate for married women with no children was 779 in contrast with a morbidity rate of 1364 for women with more than four children.**

458 women reported an illness in the former category, while 718 women reported an illness in the latter group. It is not surprising to find a relationship between morbidity and the reproductive history of women. For women between 18-45 years, those with no children have the lowest morbidity rate of 732, while those with one of two children had a morbidity rate of 936, those with more than three or four children had a morbidity rate of 1354, which rose to 1472, when the women had more than four children. Having more children not only implies a more prolonged and strenuous period of childbearing; it also means a much heavier burden of household and child-rearing work. Hence, it would be incorrect to attribute women's illness merely to higher parity while ignoring the gender inequality in the division of household labour.

Morbidity is the result of compounding of stress factors such as advancing age, childbearing, poverty, social isolation and life-style. These factors add nuances to the overall high reporting of morbidity by adult women. Not surprisingly, we find that morbidity is highest among women who have borne

a heavier burden of child bearing as well as ever-married single women who have low social status.

Work

Household work is inevitably part of every woman's life. Besides, a majority of the adult women also engage in wage work or in household production. In the sample, 42.2 per cent of all women were engaged in an income earning activity. While in the rural 50.54 of the women were employed, in the urban areas, only 38.28 of the women had a similar status. However, 70 per cent of the 'working women' in the rural areas were engaged either entirely or partially in household farm production. Therefore, very few rural or urban women had an independent source of income. It must also be noted that the rest of the women workers were employed in low paying informal sector occupations. However, an occupation-specific analysis of morbidity is difficult due to the small number of women in every category.

The morbidity rates for housewives and earning women were 1093 and 1055 respectively – not a significant difference except that a clearer pattern emerges in urban area with earners having the highest morbidity rate of 1231. As most rural women workers are employed in household production, their status as workers is obscured. Also, a significant part of agricultural operations take place in and around the house. Hence, it is unlikely that the work routines of 'housewives' and 'earners' in the rural areas will be perceptibly different. In the urban areas, where the workplace is distinct from the household, the morbidity rates or 'earners' show a perceptible increase. This clearly indicates not merely the effect of 'double burden' of work on women's health, but also the link between perception on illness and work status. Finally, morbidity for 'housewives' is also significantly high, indicating that domestic labour in itself places a heavy burden of ill health on women.

Education

There is no strong co-relation between education and morbidity. However, the morbidity rate declines with increasing education among urban women. The ill person's rate does not show a similar trend. There is no direct relationship between formal education and perception of illness. It has often been argued that higher education in itself would raise awareness about illness and, reporting of morbidity. However, that phenomenon is certainly not visible in this study. Among urban women, where the general consciousness about health is high, regardless of educational achievement, even the least educated women report the highest morbidity. As women's education is dependent on socio-economic status of the household, this finding indicates a relationship with class rather than education. **The fact that low or no education does not inhibit the reporting of morbidity, especially in the urban areas, in this study is an important finding. This indicates that articulation of health problems does not depend on educational status, but may be influenced by factors such as exposure to the media, to health facilities and political consciousness.**

In itself, the quantum of illness among any group of women is only an approximate indicator of their health problems. That adult women, in general, suffer high morbidity is conclusively proved by the above analysis. Although the reporting of illness is dependent on many subjective factors, we do find strong evidence to support a few observations. Marriage, motherhood, household responsibility, the need to earn and the absence of other women in the household are significant factors contributing to high morbidity. The cultural and socio-economic status of the household also affects women's morbidity, wherein the disadvantaged bear a heavier burden of ill health. The location of the community as measured in its access to services has deep impact on the perception of ill health. Women in remote settlements, who do not perceive illness are, in fact, very likely to be the most ill, but our methodology fails to take note of it.

Type of morbidity

A more detailed analysis of the type of morbidity as reflected in the total female episodes (Table 4.10)

shows that of the reproductive problems, a large proportion were related to maternity and contraception (41.9 per cent) and menstrual irregularities (31.21 per cent). Reproductive tract infections accounted for less than one fifth of all the reproductive problems (18.1 per cent). It is very probable that infections have been under reported because of inhibitions and also that the symptoms of R.T.I s are occasionally not observed by women themselves. However, the burden of long-term problems resulting from childbearing and contraception are very significant. Contraception is cited as the reason for 5.36 per cent of all the episodes and 23 per cent of reproductive problems. Likewise, pregnancy, childbearing and abortion are cited as a reason for illness in 4.5 per cent of the total episodes and 15 per cent of the reproductive problems.

This indicates that reproductive health must be viewed not merely in terms of treating acute infections and of pre/post natal care, but as importantly as the management of long term problems resulting out of the stress suffered during childbearing and contraception use. **It is noteworthy that post delivery / abortion / sterilisation care, which are important in preventing long-term morbidity remain the weakest links in the public maternal and child health programme.** While mortality due to maternity is still very high and well recognised, the health implications of morbidity related to maternity need to be regarded seriously. Similarly, while sterilisation as a family planning method is promoted, the morbidity related to that has been given scant attention. Women continue to associate morbidity with these particular events for a considerably long period after they have happened. This may not be an entirely subjective perception; the scientific basis must be explored. Also, it is necessary to probe whether these events become more traumatic for women due to external factors such as poor medical care, lack of adequate rest, lack of freedom to make individual choices and the general subjugation of their bodies.

Symptoms indicating weakness (either as general weakness, tiredness, anaemia, or weakness with pain of extremities with tingling, etc.) accounted for 176 episodes. Night-blindness, which results from vitamin deficiency, has been categorised as part of weakness. 84 episodes have night-blindness as their main symptom. Reporting of weakness as a general feeling of ill health is common among women. Equally common is the tendency among professionals to dismiss it as a 'vague, non specific' experience. However, the overwhelming numbers of such complaints received in our study made it evident that its inclusion in a study of morbidity is necessary. That these complaints may, indeed, have a physiological basis in conditions such, as anaemia must be considered. This study considers such a category of illness as having great significance for gender analysis. "Weakness' provides the link between under-nourishment and morbidity that we observe in women.

General aches and pains account for overwhelming 462 episodes (15.8 per cent of all episodes), with another 58 episodes having headache as the main symptom. The former is another category of illness that cannot be included in a systemic classification of disease. However, the organic basis of these complaints was difficult to identify. The gender specificity of these complaints is apparent and it signifies an articulation of a general feeling of ill health. Together reproductive health problems, 'weakness' and 'aches and pains' account for 46.74 per cent of all the episodes. They also form a complex of inter-linked health problems that are gender specific. Gender discrimination in distribution of food and care adversely affects women's general health state, which is further debilitated by childbearing and the practice of contraception. All these three categories of illness are among the most invisible and neglected problems of women. Admittedly, their contribution to eventual mortality may be obscured and difficult to document. However, it would be irrational to ignore how deeply they affect the quality of women's day-to-day lives.

The prevalence of general health problems among women is also high. Although the proportion of gastro-intestinal complaints is relatively small, we find that infections predominate in this category. We find that a large proportion of gastro-intestinal problems (53.2) are exclusively complaints of diarrhoea and/

or vomiting. The remaining complaints relate to feelings of discomfort, namely, stomachache. These may not necessarily be related to infections, though the possibility cannot be ruled out.

It has been widely observed that respiratory diseases have substituted water borne diseases as the single most important causes of morbidity and mortality. We find evidence of that in this study too. Coughs and colds are almost equally prevalent comprising approximately five per cent each of all the illness episodes. A sizeable number of episodes of breathlessness are reported as well giving evidence to the increase in non-infectious respiratory health problems.

A significant 7.8 per cent of women's illness episodes were related to complaints of eyes and ears. A significant proportion was conjunctivitis episodes, which we encountered, in epidemic form in the rural area. Injuries/burns constituted 1.5 per cent of women's illnesses. A similar proportion of the illnesses could be directly related to mental stress and 'possession'

An important advantage of our data recording and classification design is the small proportion of episodes that had to be included in 'others'. These constitute only 3.5 per cent of all the illness episodes. They include a wide category of infectious and non-infectious complaints. (Non reproductive involuntary urination, bladder/kidney stones, liver complaints, piles, cardiovascular problems, diabetes, paralysis, hernia, nodes and tumours, oral health problems and ulcers in the mouth.)

While it is not possible to analyse the pattern of morbidity with relation to all variables, we have attempted to explore the major variations (Table 4.11).

Type of illness and geography

In the rural-urban analysis, (Table 4.11) there are some significant differences in the type of morbidity. **In the rural areas, 171 episodes of 'fevers' were recorded for every 1000 women.** As fieldwork in the rural areas was conducted in the months after the monsoon, there was a high prevalence of malaria in all the villages. This accounts for the high reporting of fever episodes in the rural sample. **However, 'fevers' as a category of illness becomes less significant in the urban areas, where we find higher number of respiratory problems (136 episodes per 1000 women).** Reproductive problems also become significantly more prevalent. In the rural households, women could never be interviewed in privacy and individually. Therefore, it is not surprising that reproductive problems are recorded less frequently in the rural households. It is noteworthy that in spite of the low level of environmental hygiene that we observed, gastro-intestinal problems do not constitute an overwhelmingly large proportion of the illnesses, either in the rural or urban areas. Surprisingly, aches and pains are more prevalent among the urban women in spite of the fact that they are younger and undertake less manual work. Though the numbers of episodes become too small, we find that weakness, injury/boils/burns, mental stress and other problems are all more prevalent among urban women. **In general, we find that morbidity in the urban women is spread more evenly across the various categories and, thus, shows more variation.** This may be seen as a result of their being more articulate in describing their health problems in a manner suitable to the study. It is also worth noting that probing was more effective among the urban women. This, evidently, increased the variation in the type of morbidity reported by them.

Type of illness and socio-economic class

An analysis of type of morbidity with the socio-economic status of the household shows no specific relationship (Table 4.11). The distribution of illness by type in all the categories is similar. Reproductive illnesses, aches and pains, fevers and respiratory illnesses constitute the most important problems in each group. As to the prevalence of each type of illness across the groups, the lowest class has the highest prevalence of both reproductive illness as well as respiratory illnesses, which declines progressively. However, in the case of the other health problems, there is no consistent relationship. Overall, the prevalence of all types of illnesses, except fevers,

is higher than average in the lowest class. Conversely, in the highest class, the prevalence of all types of illness, except 'fevers' and 'others', is lower than average. This indicates that deprivation does not increase vulnerability to specific health problems, but has a general effect of increasing ill health.

Type of illness and life stage

The most significant analysis of type of morbidity is, expectedly, yielded in relation with age (Table 4.11). There is universal increase in the reporting of all types of morbidity among adult women. Adjusting for probing does not alter this pattern. The only category where we observe a contrary movement is 'fevers', which are highest among girls below 18 years. Among the young girls and women, we find that fevers and respiratory illnesses account for the bulk of all morbidity. Sense organ problems constitute the other significant group.

Among adult women, there is a shift in the pattern of morbidity. It is important to note that general health problems do not become less prevalent. More than 100 episodes of fevers for 1000 women are recorded consistently for each age group. However, we find that the prevalence of the 'gender specific' health problems identified by us rises sharply. Among the adult women too, we find a very distinct illness profile for younger and older women. Reproductive problems, which are highly prevalent among the younger women, decline considerably for women above 45 years. However, they are substituted by a heavy load of weakness and aches and pains. Respiratory problems and problems of the sense organs also become very significant among these women. Thus there is a combination of degenerative and infectious diseases afflicting this group.

Since all these women belong to the same households, there is a pattern of morbidity developing through the life span of these women. It is logical for individuals to relate their ill health to the roles that preoccupy them most at that point. The social construction of illness also depends greatly on the role that women perform in society. As has already been noted, our classification of illness depends almost entirely on the respondent's perception. Hence, it is to be expected that the pattern of morbidity will reflect the social role that women perform and their predominant concerns. Women in the younger age group are more likely to be involved with pregnancy and childbirth. However, it must not be forgotten that the older women have undergone an equally, if not more arduous phase of reproduction. The incremental effect of childbearing and hard physical labour is seen in old age, but not perceived as being so. Childbearing is dissociated from illness by older women.

However, the difference in the pattern of morbidity among women of each age group must be understood in a continuum, as progressing through a life span. For example, backache is a common complaint for adult women. There are 29 complaints of backache for 100 women in the 18-45 years age group, while there are 25 complaints of backache for every 100 women above 45 years. This reveals that backache is equally prevalent in both groups of women. It is also to be expected that this problem commences in youth and continues into old age. However, among the younger women, a majority of these complaints are related to maternity and contraception. In old age, these problems remain but are attributed to causes such as ageing, over-work and weakness. Consequently, while there are 323 episodes of reproductive problems among women between 18-45 years, there are 318 episodes of aches and pains for every 1000 women in the eldest age group.

The profile of illness for each age group is distinct. While for girls below 18 years, respiratory problems and fevers predominate, the adult women have a high burden of reproductive problems and aches and pains, in addition to fevers. In addition to ill health caused by environmental factors, they must contend with the problems related to work, childbearing and deprivation. This outlines the need for viewing women's health problems from a wide perspective. Their problems are complex and interwoven. Thus, malaria is as significant a problem for sixty-year-old women as arthritis. And young women, no doubt, must be protected from R.T.I s, but they are also afflicted often enough from diarrhoea. The public

health policy of offering only specific services to women and concentrating on problems 'specific' to a certain age/life stage (e.g. maternal health) and ignoring general complaints and common infections is a fallacy that women are paying a heavy price for.

Duration of illness

The duration of illness as indicated in the previous chapter was a problematic area. Usually, we find that there is a preponderance of short-term acute illnesses in any household survey. However, the duration for episodes recorded prior to probing themselves indicates the difference between male and female morbidity (Table 4.12). Only 52.4 percent of the episodes reported by women have duration of a week or less. This is in contrast to the duration of male illness, which was of short duration. The episodes reported after probing are generally of much longer duration, largely between one month and five years. It is evident, therefore, that probing resulted in the recording of a large number of chronic illnesses. Hence, in the episodes recorded without probing, 72.9 per cent have duration of four weeks or less while in the episodes recorded after probing, 55.2 per cent of the episodes have duration of more than one year.

Duration and type of illness

Also the duration of various types of illness vary greatly (Table 4.13). For example, 89 per cent of the fevers, 70 per cent of the respiratory problems, 79.1 per cent of the injury / burns / boils and 54.3 per cent of the gastro-intestinal complaints had a duration of four weeks or less. In contrast, more than 40 per cent of reproductive problems, aches and pains, weakness related illness, as well as mental health problems have duration of more than one year to 10 years. It is important to note here that the recording of duration of illness was based entirely on the response of the woman. We observed that a wide range of illnesses would be perceived as originating in one traumatic event (e.g. a miscarriage, or even death of a loved one). It was impossible for us to probe deeper into the duration of the long-term illnesses because no treatment was sought for them. Neglect could also be a factor contributing to the prolonging of the illness. It is noteworthy that the types of illness observed to have long-term duration are rarely debilitating enough to prevent activity altogether. Hence, they are also most likely to be neglected. However, they are persistent low intensity problems that considerably lower the women's feeling of well-being.

There is a significant difference in the duration of illness in the rural and urban households. 44.3 per cent of the rural episodes have duration of four weeks or less, compared to 28.4 per cent in the urban households. Even after adjusting for probing, urban women have, on average, reported a longer duration of illness. Access to treatment and health care is an important factor in shortening the duration of illness. However, as we will observe in the following chapters, access to health care in the urban areas is also very poor. With changing perceptions of illness, the awareness of bodily discomfort becomes more acute. In spite of advances in medicine, certain illnesses remain untreatable. For e.g. chronic back or body pain due to long hours of manual work; their cause may be traced to gender division of labour, coupled with lack of rest and insufficient nutrition. Though women have attained awareness of pain, they are powerless to remedy it. The presence of such long duration illnesses is not so much a sign of the intractability of disease as much as a reminder of the fact that women's roles remain unchanged and tedious. The greater reporting of long term illnesses among urban women may be seen as a result of a greater awareness of health problems.

The reasons for illness and links to life events

In 74 per cent of the female episodes, a reason for illness was stated (Table 4.14). In 4.5 per cent of the episodes, two reasons were stated for illness. We find a high degree of correspondence between the pattern of morbidity and the stated reasons for illness. In contrast to the males, **non-environmental causes are frequently cited by women for their illness. This is in keeping with the finding of a large**

number of non-infectious and long-term illnesses among women. The wide variation in the reasons stated for illness is also an indicator of the complexity of women's perception of their health. For example, childbirth, contraception, menstruation, intercourse etc. comprise 22.8 per cent of the reasons stated for illness. A substantial 15.7 per cent of the reasons revolved around the effect of work and fatigue on ill health. Only 29.9 per cent of the reasons were directly related to the physical environment, food or the presence of an epidemic. A category of illness such as mental stress/illness can be attributed to many different causes. While most of these episodes are caused by general feelings of anxiety and 'tension', some of the episodes are specifically linked to grief (5 episodes), violence (3 episodes), infertility (2 episodes) and even old age and fatigue (2 episodes).

How women perceive illness is closely related to their lives and their dominant concerns. The reasons for illness reported by women of different ages are markedly different (Table 4.14). This also corresponds to the difference in the type of illness reported by each age group. Not surprisingly, 66 per cent of the reasons for illness among girls below 18 years are related to environmental factors and epidemics. For women in the childbearing age, reproductive reasons constitute 33.6 per cent of the stated causes of illness. It is worth noting that the second most important reason is work-related stress. In the oldest age group, we find that 43.8 per cent of the reasons are comprised of work, fatigue, weakness and ageing. As we had earlier observed in the case of back pain, the same symptom/complaint is attributed by women of different ages to different reasons. That ill health must be understood in sociological terms, not merely medical terms, is evident from this example.

Similarly, we find some degree of co relation between women's work and their perception of illness. 22.1 per cent of the earning women's reasons were related to work and fatigue in comparison with 10.65 per cent among house-workers. They also associated emotional trauma, injury and stress/addictions more frequently with morbidity than house-workers. Remarkably, we find that 'environmental reasons' and reproductive reasons are present in the same proportion among both these groups of women. While house-workers cite weakness/old age more frequently as a reason for illness than earning women. This analysis demonstrates that factors such as stress, fatigue and weakness are perceived differently by each group of women. And is evidently linked to the milieu in which they live and work.

Conclusions

There is a marked difference in the illness of men and women, as well as different groups of women. Each aspect of women's lives influence morbidity in a distinct manner.

Certain factors as lack of physical access and social isolation inhibits the reporting of morbidity. However, poverty does not have a similar effect. Thus, there is a distinct co-relation between low socio-economic status and high morbidity, but not with 'access' or 'caste/community'.

The life stage of the woman has a pervasive effect on morbidity, both in terms of quantum and type. Factors, not hitherto considered seriously in studying morbidity, such as the size of household and the number of women sharing housework, are important keys to understanding what contributes to ill health among women. A gender analysis of health cannot afford to ignore these intra-household dynamics that affect women directly and, perhaps, more acutely, than men.

The rural-urban difference in type of morbidity, though marked, is not entirely predictable. Any understanding of health transition would prove insufficient in this case unless it is complemented by a better understanding of how illness is actually perceived by individuals and groups.

A little less than half of women's illnesses have continued for longer than a year. Nonetheless, they bear an equally heavy burden of acute infections as men.

Their gendered roles, as mothers and house-workers, contribute an additional load of health problems apart from the general health problems. Women's understanding of their own illness is deeply shaped by their experiences as can be observed from the range of reasons stated for illness. That they differ in emphasis in each group of women must be noted when we attempt any analysis of women's attempts to alleviate their suffering.

Table 4.1 Morbidity and Ill person's rate by sex and geography

	Persons ill	Ill person's rate	Episodes	Morbidity rate	Index	Total persons
Total Male	**1115**	**307**	**1200**	**330**	58	**3631**
Rural Male	868	326	923	346	61	2662
Urban Male	247	254	277	285	50	969
Total Female	**1812**	**506**	**2909**	**812**	142	**3581**
Rural Female	1355	512	2096	793	139	2643
Urban Female	457	487	813	866	152	938
Total	**2927**	**406**	**4109**	**570**	**100**	**7212**

Table 4.2 Type of morbidity in rural and urban households

Type of morbidity	Rural		Urban		Total	
Reproductive	386	12.8	196	18.0	582	14.2
GIT	227	7.5	74	6.8	301	7.3
Weakness	185	6.1	92	8.4	277	6.7
Aches/pain	412	13.6	193	17.7	605	14.7
Fevers	855	28.3	88	8.1	943	22.9
Respiratory	436	14.4	252	23.1	688	16.7
Sense organs	366	12.1	91	8.3	457	11.1
Injury/boil/burn	37	1.2	30	2.8	67	1.6
Mental stress	29	1.0	21	1.9	50	1.2
Others	86	2.8	53	4.9	139	3.4
Total	**3019**	**100**	**1090**	**100**	**4109**	**100**

Table 4.3 Morbidity rates among males by age group

Age group	Morbi-dity rate	Index	Number of males
0-17 years	350	106	1685
18-45 years	292	88	1370
46 years & above	373	113	479
No response	309	94	97
Total	**330**	**100**	**3631**

Table 4.4 Type of morbidity among Males

Type of Morbidity	Rural		Urban		Total	
	Episodes	Percent	Episodes	Percent	Episodes	Percent
Reproductive	2	.2	—	—	2	.2
GIT	91	9.9	22	7.9	113	9.4
Weakness	12	1.3	5	1.8	17	1.4
Aches/pain	58	6.3	27	9.7	85	7.1
Fevers	403	43.7	47	17.0	450	37.5
Respiratory	204	22.1	124	44.8	328	27.3
Sense organs	111	12.0	31	11.2	142	11.8
Injury/boil/burn	12	1.3	12	4.3	24	2.0
Mental stress	2	.2			2	.2
Others	28	3.0	9	3.2	37	3.1
Total	**923**	**100**	**277**	**100**	**1200**	**100**
Duration of episodes among rural and urban males						
Duration of episode	**Rural**		**Urban**		**Total**	
0-7 days	502	54.4	135	48.7	637	53.1
8-14 days	153	16.6	37	13.4	190	15.8
15-21 days	54	5.9	18	6.5	72	6.0
22-28 days	2	.2	3	1.1	5	.4
29-365 days	94	10.2	34	12.3	128	10.7
1 to 5 years	61	6.6	32	11.6	93	7.8
>5 to 10 years	23	2.5	9	3.2	32	2.7
>10 years	15	1.6	6	2.2	21	1.8
No Response	19	2.1	3	1.1	22	1.8
Total	**923**	**100.0**	**277**	**100.0**	**1200**	**100.0**
Reason of illness among rural and urban males						
Reason for illness	**Rural**		**Urban**		**Total**	
Reproductive reasons	2	.3			2	.2
Stress, Addiction	7	1.1	7	3.0	14	1.6
Weakness, Old age	18	2.8	9	3.8	27	3.0
Work, Fatigue	79	12.1	22	9.4	101	11.4
Epidemic	218	33.4	12	5.1	230	25.9
Food, Water, Weather	208	31.9	114	48.5	322	36.3
Other Illness, Iatrogenic	37	5.7	23	9.8	60	6.8
Trauma, Injury	42	6.4	23	9.8	65	7.3
Others	42	6.4	25	10.6	67	7.5
Total responses	653	100	235	100	888	100
Total episodes	**636**		**217**		**853**	

Note: Multiple reasons for illness were stated.

Table 4.5 Ill person's rate and morbidity rate among women

	Women ill	Ill persons per 1000	Episodes reported	Episodes per 1000	Index	Number of women
Total	**1812**	**506**	**2909**	**812**	**100**	**3581**
Rural	1355	512	2096	793	98	2643
Urban	457	487	813	866	107	938
Duration of settlement						
Original/old settler	**1371**	**508**	**2131**	**789**	**97**	**2699**
Rural	1269	511	1944	783	96	2480
Urban	102	465	187	853	105	219
All year migrants,	**364**	**501**	**629**	**866**	**107**	**726**
Rural	66	584	110	973	120	113
Urban	298	486	519	846	104	613
Others	**77**	**493**	**149**	**955**	**118**	**156**
Rural	20	400	42	840	103	50
Urban	57	537	107	1009	124	106
Socio economic class						
Non worker, unskilled	**401**	**564**	**689**	**970**	**119**	**710**
Rural	207	586	336	951	117	353
Urban	194	543	353	988	122	357
Formal sector unskilled	**519**	**519**	**818**	**818**	**101**	**1000**
Rural	397	542	587	801	99	732
Urban	122	455	231	861	106	268
Formal sector skilled	**632**	**467**	**1000**	**739**	**91**	**1352**
Rural	556	461	873	725	89	1204
Urban	76	513	127	858	106	148
Professionals, trade	**260**	**501**	**402**	**774**	**95**	**519**
Rural	195	550	300	847	104	354
Urban	65	393	102	618	76	165
Caste/community status						
Upper Hindu castes	**335**	**481**	**559**	**803**	**99**	**696**
Rural	266	504	444	842	104	527
Urban	69	408	115	680	84	169
Other Hindu Castes	**373**	**540**	**586**	**848**	**104**	**691**
Rural	302	544	449	809	100	555
Urban	71	522	137	1007	124	136
Scheduled castes	**276**	**516**	**470**	**880**	**108**	**534**
Rural	142	561	239	944	116	253

Urban	134	476	231	822	101	281
Scheduled tribes	**704**	**488**	**1075**	**745**	**92**	**1443**
Rural	603	483	902	722	89	1249
Urban	101	521	173	892	110	194
Muslims, Christian	**124**	**571**	**219**	**1009**	**124**	**217**
Rural	42	711	62	1050	129	59
Urban	82	519	157	993	122	158
Rural women by Access*						
Easy Access	617	516	971	813	103	1194
Difficult Access	603	517	926	794	100	1165
Remote	135	475	199	700	88	284
Urban women by social access¨						
Non slum	115	424	181	668	77	271
Slum	341	512	631	947	109	666

**The referent for index is rural female morbidity rate (793)*
¨The referent for index is urban female morbidity rate (866)

Table 4.6 Ill person's rate and morbidity rates among women

	Women ill	Ill persons per 1000	Episodes reported	Episodes per 1000	Index	Number of women
Total	**1812**	**506**	**2909**	**812**	**100**	**3581**
Family size						
1-5 members	**620**	**576**	**1067**	**991**	**122**	**1076**
Rural	401	611	676	1030	127	656
Urban	219	521	391	931	115	420
6-10 members	**960**	**501**	**1509**	**787**	**97**	**1916**
Rural	744	511	1125	773	95	1455
Urban	216	468	384	833	103	461
11-15 members	**189**	**422**	**269**	**601**	**74**	**447**
Rural	167	428	231	592	73	390
Urban	22	386	38	666	82	57
More than 15 members	**43**	**302**	**64**	**450**	**55**	**142**
Rural	43	302	64	450	55	142
Number of women in household						
One woman	**521**	**594**	**891**	**1016**	**125**	**877**
Rural	336	607	549	992	122	553
Urban	185	571	342	1055	130	324
Two women	**585**	**517**	**960**	**848**	**104**	**1131**

Rural	426	531	682	851	105	801
Urban	159	481	278	842	104	330
3 or more women	**706**	**448**	**1058**	**672**	**83**	**1573**
Rural	593	460	865	671	83	1289
Urban	113	397	193	679	84	284
Morbidity and Ill person's rate for women above 12 years in households with only one woman						
1-5 members		765		1500	185	362
6-10 members		828		1727	213	99
11-15 members		1000		2000	246	1

Table 4.7 Ill person's rates and morbidity rates for women

	Women reporting illness	Ill persons per 1000	Total episodes	Morbidity rate per 1000	Index	Total Women
Total	**1812**	**506**	**2909**	**812**	**100**	**3581**
Age group						
Upto 4 years	**175**	**356**	**183**	**372**	**46**	**491**
Rural	130	357	134	368	45	364
Urban	45	354	49	385	47	127
5 - 11 years	**214**	**330**	**226**	**349**	**43**	**647**
Rural	170	349	176	362	45	486
Urban	44	273	50	310	38	161
12 - 17 years	**156**	**377**	**198**	**479**	**59**	**413**
Rural	122	389	152	485	60	313
Urban	34	340	46	460	57	100
18 - 25 years	**307**	**496**	**507**	**819**	**101**	**619**
Rural	222	497	345	773	95	446
Urban	85	491	162	936	115	173
26 - 35 years	**346**	**679**	**655**	**1286**	**158**	**509**
Rural	245	696	441	1252	154	352
Urban	101	643	214	1363	168	157
36 - 45 years	**231**	**697**	**442**	**1335**	**164**	**331**
Rural	172	696	320	1295	159	247
Urban	59	702	122	1452	179	84
46 - 55 years	**178**	**687**	**339**	**1308**	**161**	**259**
Rural	130	702	250	1351	166	185
Urban	48	648	89	1202	148	74
56 years and above	**168**	**717**	**299**	**1277**	**157**	**234**
Rural	128	731	220	1257	155	175

Urban	40	678	79	1339	165	59
No response	**37**	**474**	**60**	**769**	**95**	**78**
Rural	36	480	58	773	95	75
Marital status						
Never married	**538**	**344**	**594**	**379**	**47**	**1564**
Rural	406	358	436	384	47	1134
Urban	132	307	158	367	45	430
Currently married and cohabiting	**1045**	**621**	**1920**	**1141**	**141**	**1682**
Rural	782	619	1385	1096	135	1263
Urban	263	627	535	1276	157	419
Widowed, separated, e.t.c	**229**	**685**	**395**	**1182**	**146**	**334**
Rural	167	678	275	1117	138	246
Urban	62	704	120	1363	168	88

Table 4.8 Ill person's rates and morbidity rates for women

	Women reporting illness	Ill persons per 1000	Total episodes	Morbidity rate per 1000	Index	Total Women
Total	**1812**	**506**	**2909**	**812**	**100**	**3581**
Number of living children						
No children	**127**	**458**	**216**	**779**	**96**	**277**
Rural	107	455	177	753	93	235
Urban	20	476	39	928	114	42
1-2 children	**376**	**573**	**645**	**983**	**121**	**656**
Rural	260	567	420	917	113	458
Urban	116	585	225	1136	140	198
3-4 children	**490**	**707**	**923**	**1331**	**164**	**693**
Rural	371	717	680	1315	162	517
Urban	119	676	243	1380	170	176
More than 4 children	**276**	**718**	**524**	**1364**	**168**	**384**
Rural	207	706	378	1290	159	293
Urban	69	758	146	1604	198	91
Not married	**538**	**344**	**594**	**379**	**47**	**1564**
Rural	406	358	436	384	47	1134
Urban	132	307	158	367	45	430
No response	**5**	**714**	**7**	**1000**	**123**	**7**

Earning status						
Non earners	**496**	**357**	**571**	**411**	**51**	**1389**
Rural	371	368	413	409	50	1008
Urban	125	328	158	414	51	381
House-workers	**398**	**596**	**729**	**1093**	**135**	**667**
Rural	221	605	388	1063	131	365
Urban	177	586	341	1129	139	302
Earners	**918**	**602**	**1609**	**1055**	**130**	**1525**
Rural	763	600	1295	1019	125	1270
Urban	155	607	314	1231	152	255
Education						
Illiterate	**967**	**653**	**1766**	**1193**	**147**	**1480**
Rural	774	643	1357	1127	139	1204
Urban	193	699	409	1482	183	276
Primary	**94**	**696**	**171**	**1267**	**156**	**135**
Rural	63	708	113	1270	156	89
Urban	31	674	58	1261	155	46
Secondary	**137**	**557**	**256**	**1041**	**128**	**246**
Rural	82	526	143	917	113	156
Urban	55	611	113	1256	155	90
Higher secondary	**43**	**478**	**66**	**733**	**90**	**90**
Rural	12	462	17	654	81	26
Urban	31	484	49	766	94	64
College, tech, prof'nl	**23**	**307**	**37**	**493**	**61**	**75**
Rural	1	333	3	1000	123	3
Urban	22	306	34	472	58	72

Table 4.9 Type of morbidity among women before and after probing

Type of morbidity	Before probing		Total	
	Episodes	Percent	Episodes	Percent
Reproductive	50	3.9	580	19.9
Aches/pain	125	9.6	520	17.9
Fevers	489	37.7	493	16.9
Respiratory	301	23.2	360	12.4
Sense organs	128	9.9	315	10.8
Weakness	30	2.3	260	8.9
GIT	103	7.9	188	6.5
Others	52	4.0	102	3.5
Mental stress	7	.5	48	1.7
Injury/boil/burn	13	1.0	43	1.5
Total	1298	100.0	2909	100.0

Table 4.10 Detailed type of morbidity among women

Type of morbidity	Episodes	% of sub total	% of all episodes
Menstrual problems	181	31.2	6.2
R.T.I	105	18.1	3.6
Maternity and Contraceptive related prob.	243	41.9	8.4
Other Reproductive problems	51	8.8	1.8
Sub-total	**580**	**100**	**19.0**
Weakness	176	67.7	6.1
Night blindness	84	32.3	2.9
Sub-total	**260**	**100**	**9**
Aches, pains	462	88.9	15.9
Head ache	58	11.2	2.0
Sub-total	**520**	**100**	**17.9**
Stomach ache	88	46.8	3.0
Diarrhea, Vomiting	100	53.2	3.4
Sub-total	**188**	**100**	**6.4**
Fevers	493	100	17.0
Sub-total	**493**	**100**	**17.0**
Colds	152	42.2	5.2
Cough, TB	148	41.1	5.1
Breathlessness	60	16.7	2.1
Sub-total	**360**	**100**	**12.4**
Eyes, ears problems	228	72.4	7.8
Boils, skin, hair problems	87	27.6	3.0
Sub-total	**315**	**100**	**10.8**
Injury, burns, bites	43	100	**1.5**
Mental illness, stress	48	100	**1.7**
Others	102	100	**3.5**
Total	**2909**		**100**

Table 4.11 Type of morbidity among women with specific variables

Rural and urban households									
	Rural			Urban			Total		
Type of morbidity	*Episodes*	*percent*	*Episodes per 1000*	*Episodes*	*Percent*	*Episodes per 1000*	*Episodes*	*Percent*	*Episodes per 1000*
Reproductive	384	18.3	145	196	24.1	209	580	19.9	162
GIT	136	6.5	51	52	6.4	55	188	6.5	52
Weakness	173	8.3	65	87	10.7	93	260	8.9	73
Aches/pain	354	16.9	134	166	20.4	177	520	17.9	145
Fevers	452	21.6	171	41	5.0	44	493	16.9	138
Respiratory	232	11.1	88	128	15.7	136	360	12.4	101
Sense organs	255	12.2	96	60	7.4	64	315	10.8	88
Injury/boil/burn	25	1.2	9	18	2.2	19	43	1.5	12
Mental stress	27	1.3	10	21	2.6	22	48	1.7	13
Others	58	2.8	22	44	5.4	47	102	3.5	28
Total	**2096**	**100**	**793**	**813**	**100**	**867**	**2909**	**100**	**812**

Age groups								
Age group	**0 - 17 years**		**18-45 years**		**Above 45 years**		**No response**	
Type of morbidity	*Episodes*	*Episodes per 1000*	*Episodes*	*Episodes per 1000*	*Episodes*	*Episodes per 1000*	*Episodes*	*Episodes per 1000*
Reproductive	41	26	471	323	59	120	9	115
GIT	45	29	96	66	46	93	1	13
Weakness	7	5	159	109	83	168	11	141
Aches/pain	36	23	306	210	157	318	21	269
Fevers	227	146	189	130	71	144	6	77
Respiratory	157	101	119	82	81	164	3	38
Sense organs	69	44	142	97	98	199	6	77
Injury/boil/burn	7	5	28	19	8	16		0
Mental stress	1	1	36	25	9	18	2	26
Others	17	11	58	40	26	53	1	13
Total	**607**	**391**	**1604**	**1099**	**638**	**1294**	**60**	**769**

Socio-economic class of household								
	Non-Worker, Unskilled		**Formal Sector /Unskilled**		**Formal Sector Skilled**		**Professionals, Trade**	
Type of morbidity	*Episodes*	*Episodes per 1000*	*Episodes*	*Episodes per 1000*	*Episodes*	*Episodes per 1000*	*Episodes*	*Episodes per 1000*
Reproductive	152	162	161	214	189	161	78	140
GIT	42	52	56	59	72	56	18	53
Weakness	69	73	71	97	86	71	34	64

Aches/pain	120	145	145	169	180	145	75	133
Fevers	93	138	146	131	179	146	75	132
Respiratory	87	101	110	123	107	110	56	79
Sense organs	70	88	82	99	125	82	38	92
Injury/boil/burn	15	12	10	21	10	10	8	7
Mental stress	17	13	16	24	12	16	3	9
Others	24	28	21	34	40	21	17	30
Total	**689**	**970**	**818**	**818**	**1000**	**739**	**402**	**774**

Table 4.12: The duration reported by women for episodes recorded with and without probing

Duration of episode	Without probing		With probing		Total	
	Episodes	Percent	Episodes	Percent	Episodes	Percent
0-7 days	680	52.4	145	9.0	825	28.4
8-14 days	177	13.6	41	2.5	218	7.5
15-21 days	78	6.0	25	1.6	103	3.5
22-28 days	11	.8	3	.2	14	.5
29-365 days	155	12.0	429	26.6	584	20.1
1 to 5 years	100	7.7	564	35.0	664	22.8
5 to 10 years	30	2.3	176	10.9	206	7.1
More than 10 years	33	2.5	150	9.3	183	6.3
No Response	33	2.5	78	4.8	111	3.8
Total	1297	100.0	1611	100.0	2908	100.0

Table 4.13 Duration of episodes reported by women according to the type of morbidity

	Duration of episode					
Type of morbidity	**Up to 4 weeks**	**31-365 days**	**1- 10 years**	**More than 10 years**	**No response**	**Total**
Reproductive	46 7.9	147 25.3	281 48.4	77 13.3	29 5.0	580 100.0
GIT	102 54.3	42 22.3	31 16.5	6 3.2	7 3.7	188 100.0
Weakness	35 13.5	82 31.5	119 45.8	11 4.2	13 5.0	260 100.0
Aches/pain	108 20.8	132 25.4	229 44.1	35 6.7	15 2.9	519 100.0
Fevers	439 89.0	29 5.9	12 2.4	2 .4	11 2.2	493 100.0
Respiratory	252 70.0	39 10.8	41 11.4	15 4.2	13 3.6	360 100.0

Sense organs	113 35.9	69 21.9	105 33.3	15 4.8	13 4.1	315 100.0
Injury/boil/burn	34 79.1	4 9.3	3 7.0		2 4.7.	43 100.0
Mental stress	2 4.2	13 27.1	20 41.7	9 18.8	4 8.3	48 100.0
Others	29 28.4	27 26.5	29 28.4	13 12.7	4 3.9	102 100.0
Total	**1160** **39.9**	**584** **20.1**	**870** **29.9**	**183** **6.3**	**111** **3.8**	**2908** **100.0**

Note: Percentages are row percentages, Missing cases =1

Table 4.14 Stated reasons of illness for women of different age groups

Reason	0-17 years		18-45 years		46 and above		No response		Total	
Reproductive	36	**7.7**	434	**33.6**	42	**8.7**	12	**21.4**	524	**22.8**
Stress, Addiction	3	**0.6**	48	**3.7**	19	**3.9**	4	**7.1**	74	**3.2**
Weakness, Old age	1	**0.2**	104	**8.0**	130	**26.9**	12	**21.4**	247	**10.7**
Work, Fatigue	21	**4.5**	243	**18.8**	82	**16.9**	14	**25.0**	360	**15.7**
Epidemic	111	**23.8**	101	**7.8**	36	**7.4**	5	**8.9**	253	**11.0**
Food, Water, Weather	197	**42.3**	157	**12.1**	73	**15.1**	6	**10.7**	433	**18.8**
Other illness, Iatrogenic	29	**6.2**	80	**6.2**	51	**10.5**	1	**1.8**	161	**7.0**
Trauma, Injury	28	**6.0**	68	**5.3**	26	**5.4**			122	**5.3**
Others	40	**8.6**	58	**4.5**	25	**5.2**	2	**3.6**	125	**5.4**
Total	466	**100**	1293	**100**	484	**100**	56	**100**	2299	**100**

Table 4.15 Stated reasons of illness for women by type of morbidity

	Type of morbidity										Total
Reason for illness	Repro.	G.I.T	Weak-ness	Aches/ pain	Fevers	Respi-ratory	Sense organ	Injury	Ment. Stress	Other	
Reproductive	436	7	32	28	2	3	3		2	11	**524**
Stress, Addiction			6	8	2	5	6	3	39	5	**74**
Weakness, Old age	28	8	91	61	7	15	33		1	3	**247**
Work, Fatigue	18	2	64	187	55	19	9	4	1	1	**360**
Epidemic		15		1	132	39	64			2	**253**
Food, Water, Weather	24	63	12	45	112	146	12	2		17	**433**
Other Illness, Iatrogenic	10	12	21	39	18	21	27	3		10	**161**
Trauma, Injury	4	7	7	26	18	10	16	30		4	**122**
Others	5	7	9	25	23	15	29	1	2	9	**125**
Total	**525**	**121**	**242**	**420**	**369**	**273**	**199**	**43**	**45**	**62**	2299

5. Utilisation of Health Care

Although the utilisation of health/curative services is only one aspect of health care, the services are important in securing good health for individuals and the lack of access to them is a reflection of an overall deprivation. Health services are known to be inaccessible for the poor and disadvantaged sections of our society, especially women.

Utilisation of health services is a complex phenomenon which is affected by various factors- people's perception about illness, severity of illness, need for health care, their knowledge about health care services, physical, economic and social accessibility of health care services, quality of care, the structure of the health system and the biases of the health care providers.

Measuring access to health care, especially in its varied forms in both the formal and informal sector is a challenge. This study has attempted to measure it by studying the type of health services available to the community, treatment of illness and utilisation of health care services.

The purpose is to understand some aspects of access to health services by looking at the **proportion of treated and untreated illness** episodes as well as **type of health facility** utilised for the treated illness episodes. Methodologically, this study defines health seeking or treatment of illness broadly, so as to incorporate all health care services and facilities. 'Treatment' includes even those services received in the form of self-care / self- medication, home remedy, healing rituals and practices (not including ceremonial rituals for good health). The idea was to include the entire gamut of utilisation of health care services in the community and to be able to analyse the health care provision without a bias in favour of formal health care services. This approach has helped arrive at the concept of "no treatment" which means episodes where *no action* has been taken to alleviate the situation, during the reference month.

'Treatment of illness' includes examination, cure and care of illness, symptoms reported and other health needs. Non -treatment is when an illness episode is reported within the recall period, and no action is taken. 'Utilisation' is defined to mean all actions taken to access knowledge, facilities, items and services to ease, reduce, eliminate, or prevent illness or specific symptoms or to cater to their health needs.

Formal and informal facilities

Households' respondents report their actions which occur in varied settings and cannot be classified into categories based on only on either type of institution or ownership or provider. In order to classify them — informal/formal —, it becomes necessary to take into account all the three factors (See Table 5.1).

Informal services are defined as those provided by lay or unqualified providers, generally not based in specialised health institutions (chemist shops being an exception). They may be entrenched in the modern market, (as with self-medication and care by unqualified private practitioners) or may be organised according to religious or social custom (traditional practitioners). Largely, informal services are more accessible — physically, economically or socially.

Formal services are defined as those provided by 'doctors' without regard to the setting. Although paramedical staff and aanganwadi workers are not thus 'qualified', they are included in the formal sector because providing curative services is a part of their job. The assumption is that their services are within the limits of their training and expertise. Also these workers are one link in the complex public health system. As providers, they have access to referral services, expert advice and emergency services for their patients, which are not available to private unqualified practitioners. However, all the formal providers identified in the study were not necessarily trained and registered, especially in rural areas. Some of them had well equipped clinics in the taluka town with in patient facilities, while others arrived on

motorcycle once or twice a week carrying an extremely limited range of drugs. They set up a temporary clinic either in a hut or even under a tree and attended to more than thirty patients in a couple of hours.

The paramedical workers were generally women – Auxiliary Midwife Nurses or aanganwadi workers residing in the village and were, thus, easily accessible. Government doctors were, perhaps, the only fully trained providers available to the rural households. They were generally to be found in the PHCs. In a few cases, the rural households accessed care from the government doctors in the sub centres or in camps. The private in-patient facilities used by the rural households were invariably in the neighbouring towns or Nashik.

There were some differences in the informal facilities used in the rural and urban households but self care practices were similar - drinking concoctions, massage, applying herbal pastes or plasters. The urban households accessed chemist shops that were mostly within walking distance where drugs were sold over the counter (without prescription). Often, people produced a foil of used tablets and obtained medicines. In rural areas, the use of self-medication was restricted to villages close to a town, or situated on the highway or main road. The traditional practitioners used by rural households could vary from the local herbalist to divine healers practising in another district. One unique case was of a family having three mentally ill brothers who were taken every month by the family in a hired jeep to a swami who gave treatment in a temple in Ahmednagar district. The use of traditional practitioners by rural households was widespread. On the other hand, traditional providers were used by urban households only for specific problems such as jaundice or to cure infertility. The providers were also often located in another town or district.

The formal and informal services differ not so much in quality as in access and availability. The classification helped study the differences in the utilisation of health care by different socio-economic groups.

Formal care is not necessarily 'better' than informal care but it is more expensive and compels the user to enter into institutionalised health systems. It is also preferred in most situations. Whether it is a general practitioner or a large general hospital, there are same hierarchies and biases that are found in the society. Thus, access to these services is limited not only by physical but also social and economic factors. Therefore, the use of formal care becomes an important variable to consider while examining the socio-economic determinants of health care use. Informal services, often similarly trapped in the modern market system, are still organised differently. They are used to supplement formal care and sometimes as a substitute for unavailable formal care. Only occasionally, they are the first choice – for apparently incurable, chronic or supernatural problems.

Total neglect of health problems expressed as *no treatment taken in the reference month* is the most accurate measure of deprivation. The episode is not treated at all, either out of inability or unwillingness to use health care at all, despite an awareness of the health problem.

Background

Little information is available about health facilities existing in the sample area. There were seven public health centres (PHCs) in Igatpuri taluka in 1994-95 (EHO; Nashik; 1995). Apart from one PHC which was established in 1964 at Ghoti, all the others were established after 1983. There were 13 posts of medical officers approved in these PHCs, of which four were vacant in 1994-95. There were 235 general beds, 52 maternity beds and 15 beds of other category and apart from maternity cases, 339 patients had been treated as in-patients. In all, 43,189 persons used the out-patient facilities provided by the PHCs in that year.

Of the villages selected, three had a PHC and six had a sub centre each while four villages had no public health facilities at all. Of the villages having a sub centre, it was closed in one village and there was no

Auxiliary Nurse Midwife (ANM) on duty. In most of the villages, the sub centre was located in the house of the ANM, who herself was living in a small rented hut. In two villages, the ANM used to commute to the village daily. The ANM had a very limited supply of drugs and equipment and had to refer cases requiring even very basic health care. In other villages, there were no curative services to speak of. A rural hospital was located in Ghoti, the largest village in the taluka. None of the sampled villages in the sample had a private in-patient facility. The nearest in-patient public facilities were located in Ghoti and Bhagur, and Igatpuri towns.

In Nashik City, there were two public hospitals, which were utilised. There was also a hospital reserved for the employees of the Mint of the Reserve Bank of India. Apart from this, there were several private practitioners and nursing homes.

Use of health care

Using three indicators - no treatment, use of formal care and informal care, the study shows that the use of health care is greatly influenced by socio-economic factors. About 62.8 per cent of illness episodes are treated (2579 out of 4109 episodes) while 37.2 per cent are not treated (1530 of 4109) (Table 5.2).

Analysed in terms of rural and urban areas, more episodes are treated in rural areas 65.2 per cent against 56 per cent in urban areas. About 34.8 per cent remain untreated in rural areas while the figure for urban area is 44 per cent. This finding does not gel with the higher reporting of illness episodes in urban areas. **It is possible to say that greater awareness of health problems does not necessarily lead to greater utilisation of health services.** That the urban sample had a predominance of poor households is a pointer to economic factors influencing utilisation.

It must be noted that while the percentage of untreated episodes without probing ranges from 18 to 20 per cent for both males and females, among episodes recorded after probing, the percentage of no treatment is 65.4 per cent. (Table 5.2). This indicates the great effect that utilisation also has on perception. As women receive no care for particular illnesses, they tend not to report them in a survey.

Also, there is a difference in the facilities utilised for episodes reported with and without probing. The 'without probing' episodes showed that 77.3 per cent of the facilities used were in the formal sector while probing revealed that the extent was only 64.5 per cent (Table 5.3).

As noted earlier, the urban sample has proportionately more poor households who have very few means to purchase health care. So, despite the fact that both private and public facilities are more concentrated in urban areas, especially Nashik city, the utilisation is less — only 60 facilities of all kinds per 100 episodes while rural households used 72 per 100 (Table 5.4).

Regarding the type of facilities utilised (Table 5.5), there are some marked differences between rural and urban use. While rural households used 57 formal facilities for 100 episodes, the corresponding figure for urban households was only 37. More informal facilities were used in the urban areas, largely self-care and self-medication. The easy availability of drugs over the counter in urban areas also leads to greater use of informal facilities. Thus, **a pattern emerges in urban areas — a high rate of no treatment, more use of informal care and less use of formal care.**

Further, among the informal services used in urban areas, chemist shops account for more than half. This indicates the high use of self-medication by the urban households. In contrast, government doctors and paramedics together account for 23 per cent of the total rural health care services used and 29 per cent of the formal facilities used. The use of traditional practitioners is expectedly higher in the rural areas. In general, private practitioners account for more than half of the total facilities used by both urban and rural households and more than 70 per cent of the formal facilities utilised. However, it is worth noting that 25.1 per cent of all facilities used are in the informal sector. Most surveys do not record the use

of these services. When combined with the fact that a large proportion of episodes are not treated at all, it shows the extent to which people, especially women, have been marginalised from the formal health care system.

Regarding access to formal care, there were 0.38 visits per person to a private or government doctor in the rural sample, while there were 0.29 visits recorded per person in the urban sample. Taken together, this figure was 0.35. It is necessary to consider the information for men and women separately. While the figure for rural men was 0.31 visits per person per month, urban men recorded 0.23 visits. For rural women, the figure was 0.45 and for urban women 0.35. There was health care utilisation in some measure even for the additional morbidity, which is reflected, in the higher number of visits recorded for women.

About the rate of treatment for the different type of illnesses, there is a predictable pattern (Table 5.6). **The most neglected illnesses are mental illnesses, reproductive illnesses, weakness-related illnesses. Less than one third of these were treated. Importantly, women reported these illnesses predominantly.** While it is true that many of these episodes were reported with probing, there is reason to believe that reproductive problems and weakness would be more common among women than men. Neglect places a heavier burden on women's health. Conversely, acute infections are very frequently treated, with 86 per cent of 'fevers' receiving attention. Since these illnesses are most frequently reported in a general household survey, the rate of no treatment does not seem to be so high. However, a gender specific study such as this finds a very high rate of untreated illnesses because the pattern of illnesses reported is itself very different.

Utilisation of Health Care by Men

Of the 1200 episodes reported among men, 212 (17.7 per cent) were not treated (Table 5.7). There is a significant difference in the treatment rate for urban and rural men. While 16 per cent of rural episodes remained untreated, the figure was 23 per cent for urban areas despite the fact that reporting of morbidity in urban areas was lower for men. Also, urban men used 25 informal facilities for every 100 episodes of illness and 71 formal facilities were utilised. There is a variation in the type of facilities used by men in the rural and urban areas. While rural men used 16 informal facilities for every 100 episodes, urban men used 28 such facilities. In contrast, 75 formal facilities per 100 episodes are used in rural area, while only 56 formal facilities are used in urban areas. This indicates that not only is there more neglect in the urban areas, informal care is also used to substitute formal care in the urban sample.

This is the result of the urban sample selected which had a high predominance of poor households. Only 12 per cent of the episodes of men living in non-slum households were not treated, in comparison to 26 per cent in slum households. A similar disparity is to be found in the use of facilities. Men in the non-slum urban households used 22 informal facilities and 68 formal facilities per 100 episodes. In contrast, men in slum households used 30 informal facilities and only 53 formal facilities per 100 episodes. Also 22 per cent of the facilities used by the men in rural households were in the state sector, as compared to 9 per cent in urban households. The other major difference was that self-medication from chemist accounted for 21 per cent of the total facilities and 64 per cent of the informal facilities in urban areas. Self care also accounted for 10 per cent of the facilities utilised in urban areas.

Utilisation of Health Care by Women.

The use of health care by women is significantly different from men. Not only is there a difference in the quantum of care used, but also in the type of facilities utilised and the nature of treatment sought. In this study, health care use was studied in relation to morbidity (i.e. 'what did you do for a particular illness'). As the purpose was to study women's illness, health care used by women must be studied separately from men. The choice between care in the formal or informal sector is dependent on many factors. Especially in the case of women, it would be wrong

to assume that formal care would always be preferred to informal care. The nature of some of women's health problems makes the use of self-medication and self care an important and essential part of looking after oneself. This is especially true of chronic problems such as aches and pains that result from women's work routine.

However, it must also be acknowledged that, often, informal care, although inadequate, is used because the formal health care system is out of reach. Finally, the complete absence of any action (opportunity) to seek care must be taken into account in the study of use of health care. **In order to understand the various factors that influence the use of health care, three aspects have been studied in greater detail — The percentage of episodes left untreated, the percentage of episodes treated first in the formal system and in the informal system.** As discussed earlier, these are only approximate indicators of access to care, but when viewed in combination with the perception of illness and expenditure on health care, they provide credible answers to the question – what makes women vulnerable to neglect?

Geography

As noted in the earlier chapter, morbidity among women in urban areas was higher than among the rural women in terms of number of episodes, but lower in terms of number of women ill. In general, the rate of treatment for the illnesses was very low. Thus, 51.3 per cent of all the episodes among urban women were not treated at all (Table 5.8). In contrast, 42.9 per cent of the episodes in rural areas were not treated.

Among the urban women, there is a significant difference between the access to health care of women living in slum and non-slum localities. While 40.9 per cent of the episodes of non-slum locality women were not treated, 54.4 per cent of the episodes of slum locality women were not treated. **Given the fact that physical access is the same for both categories of women, it is the social and economic barriers to health care, which are insurmountable.**

In rural areas, 48 facilities in the formal sector were used for every 100 episodes, while for urban areas the figure is only 30. However, the use of informal care is significantly higher in the urban areas. This may be on account of the easy availability of medicines without prescription and greater confidence in using them without supervision. Also the pattern of illness in urban areas, with a high predominance of long-term non-infectious illnesses, makes the use of services in the informal sector such as self-care and self-medication more likely. Women in non-slum localities, who have more access to formal health care use more of both formal as well as informal health care.

Access

Among rural households, physical access to health care and to other facilities varied considerably. Women in remote areas recorded lower morbidity than other rural women, which showed a lack of consciousness about health problems. The extent of their deprivation can be seen from the fact that as much as 47 per cent of the few episodes recorded were left untreated. Their access to formal health care was extremely poor. They used only 40 formal facilities for every 100 episodes. Surprisingly, their use of informal care is not considerably higher than other rural women.

It is no longer useful to conceive of health care in the informal sector as dependent on the use of indigenous resources. Informal sector care is also highly integrated into the market system, especially in the form of self-medication using allopathic drugs. As noted in the first chapter, **most of the remote rural households were land-less and poor. Given the fact that both their economic as well as physical access to services is low, it is not surprising that neglect, not self care, takes the place of absent formal health care services.**

Duration of settlement

Being a migrant reduces one's capacity to access health care because of a poorer social network as well as

poorer knowledge about the availability of facilities. Also, **migrants usually have a lower socio-economic status which limits their access to health care**. In the use of health facilities, there is a fairly significant difference between migrant and non migrant households. While 47 formal facilities were used by old settlers for 100 episodes, the figure was 33 for migrants.

Also, 51.4 per cent of the episodes among the migrant women were not treated as opposed to 43.6 per cent in the old settlers. While the use of formal services by migrants is marginally higher in rural areas; the rate of treatment is similar to that of settled households. Migrant women used public health care marginally more often than old settlers, it means higher use of formal care. In urban areas, relative neglect is evident among the migrant households where the rate of treatment as well as the use of formal health care is lower. **In general, health care is utilised less by migrant women.**

There is a vast difference in the cost of health care used by settled and migrant households, the cost being almost twice as high for settled households. This is in spite of the fact that public i.e. free facilities are used in equal proportion by both groups. The only significant difference being that migrants resort more frequently to self medication than settled households.

Socio-economic class

Unlike morbidity, **there is a high degree of co relation between socio-economic status and use of health care. Both the rate of treatment and the use of formal health care are higher among women of the higher socio-economic group.**

The class bias in the use of formal care is very distinct. While 53.3 per cent of the episodes among households in the lowest class are not treated, 39.6 per cent of the episodes of the highest class are not treated. Significantly, the use of informal health care is equally prevalent among all the groups. This indicates that informal care is used to supplement formal health care by the upper class and not to substitute it. In the absence of formal health care, for the poorest class, complete neglect takes place as reflected in the higher percentage of untreated episodes. It is significant to note that among the poorest women in the urban areas, the use of informal care and formal care is both low. The disparity between the poorest and the second lowest class is greatest while there are only minor differences in the utilisation pattern of the upper three classes. This shows that the poorest section is completely marginalised, even in the highly developed health systems.

Caste/community

Cultural factors do play a significant role in determining access to health care (Table 5.9). In rural areas, where the minority community households were all located in villages on the main road their use of formal services as well as the rate of treatment is high whereas in urban areas, the morbidity of minority community women and scheduled caste women is greatly neglected.

Muslim/Christian women used only 19 formal facilities for every 100 episodes while upper caste Hindu women used 40 formal facilities for 100 episodes. 59.7 per cent of the episodes of urban scheduled caste women were not treated. Muslim urban women rely greatly on informal care. The minority and scheduled caste women resided primarily in the slums in the urban areas. Thus, their inability to access formal health care must be seen to result from a combination of cultural and economic factors. On the whole, we find that the access of scheduled caste women to health care is the poorest, as is their access to formal facilities.

Composition of the household

Morbidity among women was higher in smaller households as well as in households with fewer women — explained by the fact that a heavier burden of work is imposed on such women. However, there are only marginal differences in their health care seeking behaviour. Facilities in rural areas are at a much greater distance than in urban areas. Thus, not

only does a women require more time to seek these services but also needs family members to accompany her. Hence those living in smaller families are disadvantaged.

The number of women in the households also affects the pattern of treatment for women in rural areas more visibly. Fewer episodes are left untreated in households with three or more women. The use of formal care for women is also much higher for such women. In urban areas, however, we find that the differences are very small and inconsistent though, here, too, the highest percentage of untreated episodes are to be found among single woman households. However, the health care seeking behaviour of women in single woman households of varying sizes does not show any difference. This is contrary to the finding that morbidity is higher among women living in larger single-woman households.

To extend the understanding about the relationship between work and health for women, we must study the process of seeking health care in the household in much greater detail. With a better understanding of the value placed on women's work in households and the process by which women support each other in the household, these links will become clearer.

The position of the household is an important determinant of the opportunities available to women to seek health services. Intra-household factors alone are relied upon to provide a complete understanding of a woman's life situation but social research cannot neglect the traditional paradigms of class, caste and culture in a study of women's health. Not only do women see their lives and fates as inextricably linked to that of their households and community, they are also active players in evolving the relationship of these groups to the larger community. Though it is not possible here to analyse in detail how the class/caste consciousness is reflected in their everyday individual lives, we cannot lose sight of it

Life stage

The type of morbidity among women of different ages varies significantly. Still, it was possible to trace the history of women's health problems through their life and find that each life stage adds on a certain set of problems to the existing condition of ill health. Thus, women's morbidity continues to rise till old age. To complement this finding, **the study showed that young adult women's and aged women's access to health care was very poor (Table 5.10).**

While women between 18 and 45 reported the highest number of untreated episodes and the lowest use of formal care, the condition of aged women was not significantly better. On disaggregating data obtained with and without probing, there was no significant difference in the health care use of women and small girls. An equal proportion of episodes were left untreated for both (18 to 20 per cent). Thus, the stark difference in morbidity that was to be seen between women of different age groups was not to be found in the utilisation of health care where **the absence of health care seeking was uniformly high for women of all age groups.**

Marital status

In terms of marital status, currently married women had the lowest use of health care, as also of formal care. Ever married single women showed marginally higher use of health care. Unmarried women had the highest use of health care. This suggests that **there is no simple relationship between marital status and access to resources.** While, it is true that ever married single women are more likely to be heads of the household, it would be wrong to assume that they automatically have higher access to resources. This is because the freedom to make decisions is not accompanied by availability of resources. At the same time, to assume that currently married women are deprived due to their subordinate position in the household would be inappropriate. Their access to health care depends greatly on the position of their households and the composition of the family.

Number of living children

An interesting co-relation of use of health care is to be found with the number of living children that a

woman has. In general, **the proportion of untreated episodes was marginally higher with an increase in the number of living children.** This complements the finding that morbidity is higher among women who have more children. However, disaggregating data for rural and urban women showed this trend among rural women but no distinct trend was visible among the urban women. This may, of course, be the result of the fewer numbers of women available for comparison. There was no difference in the use of facilities.

On analysing the information for women between 18-45 years, it showed that the proportion of untreated episodes increased with increase in the number of living children. However, the use of formal and informal facilities did not show any consistent trend. As noted in the earlier chapter, problems related to childbearing (aches, pains, reproductive problems) are more common among women with more children, as also those related to ageing. As both of these types of illnesses are most often ignored, it is certain that the quantum of care received by these women is not in proportion to the magnitude of their ill health.

Work

There was no direct relationship between earning status and health care access (Table 5.11). Instead, those women who bore the responsibility of running the household were more likely to be neglected. Thus, the rates of untreated episodes for earning women and house-workers were equally high. Marginally more formal care was used by earning women. However, the greatest contrast was with non-earning women where substantially more health care was provided. As the non-earners were most likely to be young girls, this pattern of health care is understandable. It must be remembered that since the probe did not include illness among young girls, the extent of care received by them may be misjudged.

Education

There was a slight increase in the use of health care with increase in education. In general, the proportion of untreated episodes decreases as education increases. Surprisingly, the use of informal care by women with higher education was very high, largely in the form of self-medication. However, there was no distinct trend to be found in the use of formal or informal services in relation to education.

Type of facilities utilised

Type of facility used in rural and urban households

The facilities used by women were different in the rural and urban households (Table 5.12). While, in both groups, private doctors accounted for the largest number of facilities used, **the use of self-medication by urban women was considerably higher as also the use of self-care.** Rural women used 23.2 per cent of the facilities in the public sector as opposed to 10 per cent in urban households. Of the formal facilities used by rural women, more than 30 per cent were public facilities. Surprisingly, although the urban sample was pre-dominated by poor households, the use of public facilities by urban women was very minimal.

In general, it was overwhelmingly the private sector that provided care. However, it is important to note that 27.8 per cent of the facilities were in the informal sector, of which 11.9 per cent was self-care. This indicates the importance of using women's own resources in health care. The high reliance on their own resources as well as easily accessible chemists was also evident, especially among urban women, where half the informal facilities utilised are chemist shops. Rural women relied greatly on traditional healers.

The high use of informal care makes it evident that no study can concentrate merely on health care institutions for information on what women do when they are ill. The strategies used by women are varied and they connect many different spheres of life. **The use of informal care is the result of many different factors, including the inaccessibility of health care services, the gender bias of health**

care system as well as a positive search for self-reliant strategies to cope with illness.

As noted earlier, public health care facilities were utilised more often by rural women, however, public health care does not reach equitably to all villages (Table 5.13). A large share of the public health services was utilised by the households of villages where the PHC is located. Villages with neither a PHC nor a sub-centre are the most deprived. The entire concept of primary health care in India is based on creating a network of hierarchical structures. It is expected that a centrally located PHC will serve an entire circle of villages but its use remains concentrated in the village where it is located. As the component of outreach is very weak, people who do not see the PHC personnel everyday, rarely approach the health services when in need.

Hence, **while women in PHC villages received care by government doctor 19 times for every 100 episodes, women from sub centre villages utilised this service only 5 times and those from non sub-centre villages only once.** The use of the paramedic is the same in each category of village. This indicates that the outreach workers are not more active in non-PHC villages, as it is expected that they would be. Thus, neither the outreach workers nor the central PHC is able to meet the needs of villages in the surrounding area.

As expected, most of the health care is provided in out-patient institutions (Table 5.14). In patient facilities constitute 5.1 per cent of the facilities. However, it must be remembered that it is OPD services that are largely used in these in patient facilities. In the urban area chemist shops account for 20.8 per cent of the facilities utilised.

There is a distinct pattern between the structure of health facilities and type of ownership (Table 5.15). While a large majority of the private facilities are clinics or dispensaries (Outpatient Care Settings), 13.2 per cent of the public facilities were nursing homes/ hospitals. PHCs constituted 46.6 per cent of the public facilities used. This indicates that people are directly approaching the higher level facilities in the public sector possibly because the public outreach facilities and services remain neglected, under-staffed and under-equipped. Only 3.5 per cent of the private facilities were in-patient facilities; this indicates that general practitioners and pharmacist form the bulk of private providers. The religious and traditional practitioners usually worked from their own home or a place of worship such as temple, *dargah,* etc.

In terms of the individual providing care (Table 5.14), 69.2 per cent of the rural providers were 'doctors'. It is difficult to estimate how many of these were fully trained; many of them were not registered. Paramedical personnel provided care in 14.5 per cent of the cases in rural areas and 22 per cent in urban areas. However, while rural paramedics were more likely to be health workers, the urban paramedics were overwhelmingly chemists. Traditional practitioners provided care in 5 per cent of the cases in the rural areas and 3.3 per cent in urban areas. Lay providers were much more numerous in urban areas being 17.5 per cent as compared to 10.1 per cent in rural areas.

Expectedly, only 51.1 per cent of the facilities used by rural households are located in the village (Table 5.14) while 96.9 per cent of the urban households' facilities are located in the city itself. 19.3 per cent of the rural households' facilities are located in another village, a larger number (21.7 per cent) are in the taluka town and 7.7 per cent of the facilities used by them are located in the city - either Nashik or Mumbai. This indicates that the rural households have to travel considerable distances in order to secure health care. Both private and public health services are concentrated in urban and semi-urban areas. Travel increases the dependence of women on family members.

This lack of easy access to health care is also reflected in the rate of hospitalisation for rural households (Table 5.16). **While 2.2 per cent of the facilities were used for in patient care by rural households, barely 0.9 per cent were similarly used among urban households.** As rural patients have to travel over long distances for treatment, they have to be admitted for the same treatment that urban patients may avail of as outpatients. Often people are not able

to commute back to their villages on the same day and are compelled to hospitalise the patient. Also, women substantially relied on family members to fetch medicines — common in both urban and rural areas.

The physical presence of services in the urban areas does not ensure access to the urban poor who take recourse in large numbers to informal care because, among other reasons, formal care is not affordable. It is worth noting that **most women are employed in the informal sector of the economy. As workers too, they get little access to the formal health care system. Thus, they also consume health care in the informal sector** where the state has very little direct intervention and are offered no protection.

The need for transport is felt more acutely in the rural areas where fewer facilities are accessible by foot (Table 5.14). 14 per cent of the facilities used by rural women are located at a distance of more than an hour by motor vehicle while only 2.4 per cent of the facilities used by urban households are located at a distance of more than an hour by vehicle.

Type of facility and socio-economic class

Analysing the type of facilities used by a socio-economic class of women, there are no marked differences (Table 5.17). The use of private doctors is 73.6 per cent of the formal facilities for the poorest, while public sector facilities constitute 24.7 per cent. The two middle classes make more extensive use of the public facilities than the poorest class. Although the use of public facilities is, itself, very low, the fact that the poorest class does not use it extensively indicates the low level of access to these services.

Type of facility and age

There is no difference in the type of facilities used by women of different ages. The use of private facilities ranges between 69 to 72 per cent of all formal facilities utilised for all ages. The use of public sector doctors was marginally higher for women above 45 years constituting 14 per cent of all facilities utilised. However, self care and self-medication is high for women of all age groups.

Type of treatment

A maximum of two services received were taken as treatment, also two services were combined together to enable an understanding about the combination of services received at the health centre. Then, this exercise was followed by a clubbing of services vis-à-vis the main service provided because it is the main service that determines expenditure.

There emerged seven categories of type of treatment received: (1) Home remedy and self medication (2) Examination and prescription (3) Dispensing of medicine (without injection) (4) Administration of injections (with or without dispensing) (5) Administration of saline and or/ pathological tests (6) Special procedures such blood transfusion, suturing, minor surgery, making cast, tooth extraction etc. (7) Surgery and/or hospitalisation.

The type of treatment received by an individual in rural and urban households varies to some extent (Table 5.18). **In general, the use of home remedies, self-care and rituals was quite high among women.** The use of injections is more pervasive in the rural areas as is the use of saline. Self-medication and home remedy are more prevalent in the urban areas. Also, saline and pathological tests were conducted more frequently in the rural areas. This may be due to the pervasive presence of malaria in Igatpuri taluka.

Co-relating the type of treatment received with the structure of health facility showed that only 25 per cent of the care received in the in-patient facility required hospitalisation. For the rest of the times that facility was used for out patient care. This indicates the degree of centralisation in both the private as well as public services, where even primary health care has to be accessed through tertiary care settings located at a considerable distance in urban areas.

There are some differences in the practice of private

doctors and government doctors — the former use injections in a substantially greater proportion of cases. In the government sector, this is almost completely substituted by dispensing medicine. Though nothing conclusive can be said about the rationality of their practice, the misuse of injections is very common in the private sector as it provides a rationale to charge higher fees. This has created a belief that injections are more effective than orally administered drugs. So widespread is the misconception about injections being more effective that often it is found that people refuse to use government services because they usually give only medicines.

Type of morbidity and utilisation

There is a great variation in the type of illness reported and the care received. (Table5.19) Gender related illnesses, such as reproductive problems and 'weakness' related problems were neglected to a great extent. Mental stress related problems received the least amount of care. Women are conditioned to accept many painful, discomforting bodily and mental states as 'part of life.' Thus, they were not even able to explain what was happening to them. Certain illnesses get transformed into 'legitimate' experiences — for e.g. anxiety manifesting itself as loss of appetite or indigestion. Though efforts were made to correctly identify problems, some displacement may have occurred in several cases in this study. But the fact that women were able to articulate 'minor problems' in such large numbers in the absence of any care / use of health care indicates their great need for health care and knowledge.

An analysis of the type of care used for each type of illness showed (Table 5.20) that the use of private doctor is predominant in all the cases. Only 8.5 per cent of the facilities used in 'fevers' were informal. 63 per cent of the facilities used to treat sense organ problems were in the informal sector, largely self-medication. Though the numbers are very small, mental stress related problems are referred to traditional practitioners. It is also important to note that the government paramedic (mainly, the female MPW) is used frequently for treatment of fevers and GIT problems. It is likely that if provided with adequate training and resources, a larger proportion of infections would be referred to her. **Surprisingly, 71 per cent of the facilities used in reproductive illnesses are formal services as are 75 per cent used in 'weakness' related problems. This indicates that women prefer to use formal services for these problems.** However, access to these services is so poor, that the majority of these problems remain untreated. On the whole, however, the pattern of treatment does not differ radically with type of illness.

However, the rates of treatment for different types of illnesses themselves are very different. An important finding is that for those illnesses, which are frequently treated, the use of formal care is quite extensive while for the neglected ones, the use of formal care is limited. **When formal care is not available, women neglect those illnesses completely.** The existing services, private and public, are not sensitive enough to encourage women to use health care. **There is adequate evidence in this study to show that people, even women refer their ailments to trusted and accessible health providers without reference to the type of illness.** This presents a strong case for a comprehensive and accessible general health care service that would be able to identify and treat most types of illnesses.

Perceived efficacy of treatment

Even the meagre treatment taken for gender related problems and sense organ problems are not very effective (Table 5.21). Only in case of fevers, nearly three-fourths of the facilities effect a complete cure while in gender-related illnesses, less than 40 per cent of the cases are completely cured. The most effectively treated illness was 'fevers' followed by GIT problems. Also formal facilities were seen to be providing more effective treatment than the informal sector. It is interesting to note that there is only a marginal difference in the perceived efficacy of treatment by a public or private health provider. Anecdotal information suggests that the perception common among communities is that health care

provided at the public health centres is not of good quality. However, when asked to relate information about specific illness episodes, there is no significant difference in perceived efficacy. In general, this analysis indicates that the use of informal facilities, especially self-care, does not provide adequate relief or cure in a majority of the cases.

Perceived efficacy and Duration of illness

The type of treatment also differs with the duration of illness. Long-term illnesses are treated more often with self-care; also less formal care is used. Of course, it must be remembered that self-care is used where formal care may have been utilised earlier, but unsuccessfully so. **The use of public care does not increase, but in fact, declines. This indicates that women do not seek public health care to manage long-term problems. Instead, they resort to home remedies or traditional practitioners.**

The inadequacy of using only informal care is clearly demonstrated in the analysis of perceived efficacy of treatment with the duration of illness. There is a dramatic difference in the effectiveness of treatment for short and long term problems. While treatment of episodes of less than a month's duration result in a complete cure, the long-term illnesses are rarely cured completely. However, treatment used for long-term health problems provides temporary relief. Thus, the use of health care for the most long drawn out problems is, in fact, more effective than treatment for illnesses of medium duration. This may be because the individual has developed a greater tolerance of the pain or discomfort and also has had time to evolve the best method of managing the problem.

Non-utilisation of health care

Surprisingly, in only 72.1 per cent of the cases, the use of health care seems to have any impact on the health problem. In only 51.8 per cent of the cases, a complete cure achieved. However, dissatisfaction with treatment or pessimism about its effectiveness is not the most important problem (Table 5.23). **Economic reasons are the most important obstacles in accessing health care, accounting for about 40 per cent of the untreated episodes.** Problems with health services and the treatment regimen itself accounted for 12.4 per cent of the untreated episodes. Among them, the inefficacy of treatment is a major factor. Not seeking treatment due to the nature of the illness was also an important factor in preventing access to care. 23.2 per cent of the untreated episodes were of this type. Social reasons accounted for 6.1 per cent of the untreated episodes.

There is a remarkable similarity in the reasons cited between rural and urban households for non-treatment. Economic reasons are predominant in both groups. There is no difference in the proportion of the untreated episodes where access to health facilities is an obstacle. Even within this sub group of reasons, the poor quality and efficacy of treatment is the most important reason for not seeking care. **In both rural as well as urban women, the nature of the illness itself is an important factor in not seeking treatment. In about 16 to 18 per cent of the episodes, the illness is seen to be too minor to seek treatment. However, it must be remembered that in the remaining number of cases, it is inability of the women to seek care, not their unwillingness to seek care that results in neglect.**

Conclusions

The use of health care is deeply influenced by socio-economic factors. The household's caste, religion and socio-economic status play an important role in determining access to formal health services.

Besides these, **the woman's own position in the household also affects the use of health care.** Women who bear the most responsibility for the survival of the household, heads of households and spouses of male heads, use the least health care. Also women among whom morbidity is high — women with more children, housewives and

employed women — receive very little health care in comparison to their needs.

Alarmingly, the use of health care for women declines in adulthood and remains low through the rest of her life. The presence of other women in the household may enable women to share household work and find time and resources to access health care.

In urban areas, poor women substitute the use of formal health care services with self-medication. This reflects their inability to access services that are physically so abundant in their area.

In general, the use of self-care and self-medication by women is considerable.

Many of women's health problems stem from the nature of women's work and the life cycle. Unable to reduce the stress of both, productive and reproductive labour, they learn to live with and endure suffering.

Not all of women's health problems are resolved with medical treatment. However, it is worth noting that the most frequently cited reason for seeking health care is lack of money. **It is not unwillingness, but inability to seek care that prompts women to neglect their illness. Thus, the need to stress that health care for all is a basic right is as urgent as ever.**

Table 5.1 Classification of health services as formal and informal services

	Facilities
Informal services/care	
Self care (consuming herbal or any other kinds of preparations, massage, inhaling vapours, application of ointments/lotions etc.)	287
Chemist (Self medication-buying drugs over the counter without doctor's advice)	298
Care by private sector compounder /untrained doctor/ nurse (approaching practitioners who are not registered or trained to give medical care and recognised by the respondent as being unqualified)	20
Traditional practitioners – Bhagats herbalists and indigenous practitioners (consulting the above who resort to herbal remedies or to spiritual treatment such as giving ash, sacrificing animals or giving talismans etc.	108
Total informal facilities	***713***
Formal services/care	
Care by private sector doctor (care provided by private practitioners in any setting, who to the best knowledge of the respondent are qualified doctors)	1526
Care by government sector doctor (approaching qualified doctor in any public health care institutions or in settings such as camps or village visits by PHC staff)	303
Care by government sector paramedic (care by multipurpose workers, auxiliary nurse midwives, lady health visitors or aanganwadi workers who are part of the public health system or the government run ICDS programme)	256
Care by NGO Company Charitable org' doctor (care provided by a doctor working in a dispensary/hospital run by the voluntary sector as an employee benefit measure)	19
Total formal facilities	***2104***
Not treated episodes	***1530***

Table 5.2 Rate of treatment for males and for females with and without the use of probing

Whether treated	**Male**		**Female**						**Total**	
			Without probing		**With probing**		**Sub-Total**			
	Episode	Percent	Episode	Percent	Episode	Percent	Episode	Percent	Episode	Percent
Treated	988	82.3	1034	79.7	557	34.6	1591	54.7	2579	62.8
Not treated	212	17.7	264	20.3	1054	65.4	1318	45.3	1530	37.2
Total	**1200**	**100**	**1298**	**100**	**1611**	**100**	**2909**	**100**	**4109**	**100**

Table 5.3 Type of facility used in episodes recorded with and without probing

Type of facility	**Without probing**		**With probing**	
Informal	509	22.7	204	35.5
Formal	1734	77.3	370	64.5
Total	**2243**	**100**	**574**	**100**

Table 5.4 Type of treatment for all episodes in rural and urban households

Sample	Informal Facilities	Informal Facilities Per 100 episodes	Formal Facilities	Formal Facilities Per 100 episodes	Untreated Per 100 episodes	Total Episodes
Rural	461	15	1705	57	34.9	**3010**
Urban	252	23	399	37	44.1	**1089**
Total713	**17**	**2104**	**51**	**37.3**	**4099**	

Table 5.5 Type of facility utilised in rural and urban households

	Rural		Urban		Total	
Type of facility	**Facilities**	**Percent**	**Facilities**	**Percent**	**Facilities**	**Percent**
Informal						
Self care	191	41.4	96	38.1	287	40.3
Chemist	161	34.9	137	54.4	298	41.8
Trad. Practitioners	89	19.3	19	7.5	108	15.1
Care by untrained pvt. practitioner	20	4.3	0	0.0	20	2.8
Sub total	*461*	*100.0*	*252*	*100.0*	*713*	*100.0*
Formal						
Care by pvt. doctor	1200	70.4	326	81.7	1526	72.5
Care by govt. doctor	267	15.7	36	9.0	303	14.4
Care by govt. paramedic	228	13.4	28	7.0	256	12.2
NGO, Company, any other	10	0.6	9	2.3	19	0.9
Sub total	*1705*	*100.0*	*399*	*100.0*	*2104*	*100.0*
No response	*10*	*100.0*	*1*	*100.0*	*11*	*100.0*
Total	**2176**		**652**		**2828**	

Table 5.6: The percentage of episodes treated for each type of illness

Type of morbidity	Treated episodes	Total episodes	Treatment rate
Mental stress	12	**50**	24.0
Reproductive	178	**582**	30.6
Weakness	97	**277**	35.0
Aches/pain	311	**605**	51.4
Sense organs	247	**457**	54.0
Others	80	**139**	57.6
Injury/boil/burn	48	**67**	71.6
Respiratory	527	**688**	76.6
GIT	244	**301**	81.1
Fevers	835	**943**	88.5
Total	**2579**	**4109**	**62.8**

Table 5.7 Type of facilities utilised by rural and urban males

Type of facility	Rural			Urban			Total		
	Facility	Percent of		Facility	Percent of		Facility	Percent of	
		Sub total	Total		Sub total	Total		Sub total	Total
Self care	57	37.7	6.7	23	29.5	9.8	80	34.9	7.4
Chemist	61	40.4	7.2	50	64.1	21.4	111	48.5	10.2
Trad. Practitioners	23	15.2	2.7	5	6.4	2.1	28	12.2	2.6
Care by pvt. Unqualified pract.	10	6.6	1.2				10	4.4	0.9
Sub-total	**151**	**100**	**17.8**	**78**	**100**	**33.3**	**229**	**100**	**21.1**
Care by pvt doctor	502	72.2	58.9	131	84.0	56.0	633	74.4	58.2
Care by govt. doctor	90	12.9	10.6	15	9.6	6.4	105	12.3	9.7
Care by govt. paramedic.	99	14.2	11.6	7	4.5	3.0	106	12.5	9.8
NGO, Company	4	0.6	0.5	3	1.9	1.3	7	0.8	0.6
Sub-total	**695**	**100**	**79.6**	**156**	**100**	**66.7**	**851**	**100**	**78.3**
No response	7		0.8				7		0.6
Total	**853**		**100**	**234**		**100**	**1087**		**100**

Table 5.8 Type of facilities utilised by rural and urban women

Sample	Formal Care		Informal Care		Not treated	
	Facilities	*Rate per 100 epi.*	*Facilities*	*Rate per 100 epi.*	*Episodes*	*Rate per 100 epi.*
Total	**1323**	**45**	**418**	**14**	**1318**	**45.3**
Geography						
Rural	1010	48	310	15	901	42.9
Urban	243	30	174	21	417	51.3
Accessibility of household						
Rural Easy Access	515	53	119	12	410	42.2
Rural Difficult Access	415	45	158	17	398	43.0
Rural Remote	80	40	33	17	93	46.7
Urban Non Slum	72	40	44	24	74	40.9
Urban Slum	171	27	129	20	343	54.4
Duration of settlement						
Original/old settlers	**998**	**47**	**325**	**15**	**930**	**43.6**
Rural	935	48	294	15	833	42.8
Urban	63	34	31	17	97	51.9
All year migrants, relocated migrants	**209**	**33**	**116**	**18**	**323**	**51.4**
Rural	57	52	13	12	46	41.8
Urban	152	29	103	20	277	53.4
Others	**46**	**31**	**43**	**29**	**65**	**43.6**
Rural	18	43	3	7	22	52.4
Urban	28	26	40	37	43	40.2
Socio- economic class of household						
Non-Worker, Unskilled	**229**	**33**	**110**	**16**	**367**	**53.3**
Rural	138	41	47	14	163	48.5
Urban	91	26	63	18	204	57.8
Formal Sector/Unskilled	**358**	**44**	**137**	**17**	**368**	**45.0**
Rural	287	49	86	15	253	43.1
Urban	71	31	51	22	115	49.8
Formal Sector Skilled	**475**	**48**	**163**	**16**	**424**	**42.4**
Rural	431	49	130	15	368	42.2
Urban	44	35	33	26	56	44.1
Professionals, Trade	**191**	**48**	**74**	**18**	**159**	**39.6**
Rural	154	51	47	16	117	39.0
Urban	37	36	27	26	42	41.2

Table 5.9 Type of facilities utilised by rural and urban women

Sample	Formal Care		Informal Care		Not treated	
	Facilities	*Rate per 100 epi.*	*Facilities*	*Rate per 100 epi.*	*Episodes*	*Rate per 100 epi.*
Caste/community of household						
Upper castes	**246**	**44**	**94**	**17**	**252**	**45.1**
Rural	200	45	68	15	204	45.9
Urban	46	40	26	23	48	41.7
Scheduled castes	**177**	**38**	**64**	**14**	**245**	**52.1**
Rural	112	47	31	13	107	44.8
Urban	65	28	33	14	138	59.7
Other Hindu Castes	**278**	**47**	**110**	**19**	**234**	**39.9**
Rural	234	52	75	17	173	38.5
Urban	44	32	35	26	61	44.5
Scheduled tribes	**484**	**45**	**149**	**14**	**496**	**46.1**
Rural	426	47	124	14	401	44.5
Urban	58	34	25	14	95	54.9
Muslims, Christian	**68**	**31**	**67**	**31**	**91**	**41.6**
Rural	38	61	12	19	16	25.8
Urban	30	19	55	35	75	47.8
Number of women in h'hold (only respondents)						
One woman	**235**	**33**	**106**	**15**	**717**	**56.1**
Rural	164	38	54	13	428	53.3
Urban	71	25	52	18	289	60.2
Two women	**200**	**35**	**94**	**16**	**575**	**54.3**
Rural	151	37	64	16	410	53.7
Urban	49	30	30	18	165	55.8
Three or more women	**180**	**42**	**52**	**12**	**433**	**51.0**
Rural	162	45	38	10	363	49.6
Urban	18	26	14	20	70	58.6

Table 5.10 Type of facilities utilised by rural and urban women

Sample	Formal Care		Informal Care		Not treated	
	Facilities	*Rate per 100 epi.*	*Facilities*	*Rate per 100 epi.*	*Episodes*	*Rate per 100 epi.*
Age group						
Upto 17 years	**373**	**61**	**124**	**20**	**150**	**24.7**
Rural	307	66	81	18	111	24.0
Urban	66	46	43	30	39	26.9
18 - 45 years	**612**	**38**	**254**	**16**	**814**	**50.7**
Rural	495	45	160	14	516	46.7
Urban	117	23	94	19	298	59.8
46 years and above	**257**	**40**	**99**	**16**	**309**	**48.4**
Rural	198	42	62	13	230	48.9
Urban	59	35	37	22	79	47.0
No response	**11**	**18**	**7**	**12**	**45**	**75.0**
Rural	10	17	7	12	44	75.9
Urban	1	50			1	50.0
Marital status						
Never married	**363**	**61**	**126**	**21**	**144**	**24.2**
Rural	295	68	77	18	100	22.9
Urban	68	43	49	31	44	27.8
Currently married, cohb.	**730**	**38**	**294**	**15**	**990**	**51.6**
Rural	591	43	200	14	672	48.5
Urban	139	26	94	18	318	59.4
Widowd/separated/deserted	**160**	**41**	**64**	**16**	**184**	**46.6**
Rural	124	45	33	12	129	46.9
Urban	36	30	31	26	55	45.8
Number of living children						
No children	**79**	**37**	**42**	**19**	**101**	**46.8**
Rural	71	40	34	19	78	44.1
Urban	8	21	8	21	23	59.0
Upto 2 children	**239**	**37**	**107**	**17**	**327**	**50.7**
Rural	174	41	69	16	199	47.4
Urban	65	29	38	17	128	56.9
Upto 4 children	**376**	**41**	**120**	**13**	**475**	**51.5**
Rural	304	45	78	11	337	49.6
Urban	72	30	42	17	138	56.8
More than 4 children	**195**	**37**	**87**	**17**	**267**	**51.0**
Rural	165	44	51	13	184	48.7
Urban	30	21	36	25	83	56.8
Not applicable	**363**	**61**	**126**	**21**	**144**	**24.2**
Rural	295	68	77	18	100	22.9
Urban	68	43	49	31	44	27.8

Table 5.11 Type of facilities utilised by rural and urban women

Sample	Formal Care		Informal Care		Not treated	
	Facilities	*Rate per 100 epi.*	*Facilities*	*Rate per 100 epi.*	*Episodes*	*Rate per 100 epi.*
Earning status						
Non earners	**349**	**61**	**115**	**20**	**150**	**26.3**
Rural	282	68	66	16	104	25.2
Urban	67	42	49	31	46	29.1
House workers	**264**	**36**	**108**	**15**	**383**	**52.5**
Rural	170	44	48	12	187	48.2
Urban	94	28	60	18	196	57.5
Earners	**640**	**40**	**261**	**16**	**785**	**48.8**
Rural	558	43	196	15	610	47.1
Urban	82	26	65	21	175	55.7
Education of women above 18 years						
Illiterate	**659**	**39**	**245**	**14**	**878**	**51.4**
Igatpuri taluka	558	43	169	13	639	49.1
Nashik city	101	25	76	19	239	58.7
Primary	**68**	**40**	**30**	**18**	**86**	**50.6**
Igatpuri taluka	49	44	26	23	49	43.8
Nashik city	19	33	4	7	37	63.8
Secondary	**105**	**41**	**48**	**19**	**113**	**44.3**
Igatpuri taluka	75	53	21	15	54	38.0
Nashik city	30	27	27	24	59	52.2
Higher secondary	**22**	**33**	**18**	**27**	**29**	**43.9**
Igatpuri taluka	7	41	6	35	4	23.5
Nashik city	15	31	12	24	25	51.0
College, tech, prof.	**12**	**32**	**12**	**32**	**14**	**37.8**
Igatpuri taluka	3	100		0	0	0.0
Nashik city	9	26	12	35	14	41.2

Table 5.12 Type of facilities utilised by rural and urban women

Type of facility	Rural			Urban			Total		
	Facility	Percent of		Facility	Percent of		Facility	Percent of	
		Sub total	Total		Sub total	Total		Sub total	Total
Self care	134	43.2	10.1	73	42	17.5	207	42.8	11.9
Chemist	100	32.3	7.6	87	50	20.8	187	38.6	10.7
Trad. Practitioners	66	21.3	5.0	14	8.05	3.3	80	16.5	4.6
Care by pvt. Paramedic/unqualified	10	3.23	0.8		0		10	2.07	0.6
Informal (sub total)	**310**		**23.5**	**174**		**41.6**	**484**		**27.8**
Care by pvt. Doctor	698	69.1	52.8	195	80.2	46.7	893	71.3	51.3
Care by govt. doctor	177	17.5	13.4	21	8.64	5	198	15.8	11.4
Care by govt. paramedic	129	12.8	9.8	21	8.64	5	150	12	8.6
NGO, Company, Any other	6	0.59	0.5	6	2.47	1.4	12	0.96	0.7
Formal (sub total)	**1010**		**76.5**	**243**		**49.1**	**1253**		**72.0**
No response	3		0.2	1		0.2	4		0.2
Total	**1323**			**418**			**1741**		

Table 5.13 Public facilities utilised by rural women

Type of village	Care by Govt. Doctor		Care by Govt. Paramedic		Total Number of episodes
	Facilities	Per 100 episodes	Facilities	Per 100 episodes	
PHC	131	19	37	5	688
Sub Centre	41	5	62	7	883
Non Sub Centre	5	1	30	6	525
Total	**177**	**8**	**129**	**118**	**2096**

Table 5.14 Profile of facilities utilised by rural and urban women

Structure Of Health Facility						
	Rural		Urban		Total	
	Facilities	Percent	Facilities	Percent	Facilities	Percent
Home	182	13.8	77	18.4	259	14.9
Clinic, Dispensary	743	56.2	211	50.5	954	54.8
PHC	159	12.0	3	.7	162	9.3
Hospital, Nursing home	63	4.8	25	6.0	88	5.1
Chemist, Pharmacist	100	7.6	87	20.8	187	10.7
Any Other	73	5.5	14	3.3	87	5.0
No response	3	.2	1	.2	4	.2
Location Of Health Facility						
At Home	182	13.8	77	18.4	259	14.9
Own Village/ City	494	37.3	328	78.5	822	47.2
Other Neighbouring Village	255	19.3	7	1.7	262	15.0
Neighbouring Town, Taluka Place.	287	21.7			287	16.5
Any Other (Nashik, Bom. Outside Nashik)	102	7.7	5	1.2	107	6.1
No Response	3	.2	1	.2	4	.2
Distance and vehicle used						
Less than one hour by foot	610	46.1	244	58.4	854	49.1
More than 1 hr. by foot	35	2.6	2	0.5	37	2.1
Less than 1 hr. by b.cart, cycle	46	3.5	7	1.7	53	3
More than 1 hr. by b.cart, cycle	17	1.3			17	1
Less than 1 hr. by bus, train, taxi, jeep	243	18.4	77	18.4	320	18.4
More than 1 hr. by bus, train taxi, jeep	185	14	10	2.4	195	11.2
Not applicable	182	13.8	77	18.4	259	14.9
No response	5	0.4	1	0.2	6	0.3
Type of provider						
Self, Relative, Neighbour	134	10.1	73	17.5	207	11.9
Trained Doctor	916	69.2	238	56.9	1154	66.3
Paramedic, MPW, Chemist,	192	14.5	92	22.0	284	16.3
Vaid, Hakim, Bhagat Etc.	66	5.0	14	3.3	80	4.6
Any Other	12	.9			12	.7
No Response	3	.2	1	.2	4	.2

Type of treatment						
Home remedy & self medic.	292	22.1	178	42.8	470	27.1
Examination and prescription	69	5.2	43	10.3	112	6.4
Dispensed Medicine	239	18.1	58	13.9	297	17.1
Injections	578	43.8	114	27.4	692	39.8
Saline and pathological tests	55	4.2	12	2.9	67	3.9
Special procedure	65	4.9	8	1.9	73	4.2
Surgery/hospitalisation	20	1.5	2	.5	22	1.3
No response	3	.2	1	.2	4	.2
Total	**1323**	**100**	**418**	**100**	**1741**	**100**

Table 5.15 Structure of health facilities according to type of health facilities

Structure Of Health Facility	Home Care	Private	Public	Religious, Traditional, Indigenous	NGOs, Company, Any Other	Total
Home	205 100%	39 3.6%	15 4.3%			259 14.9%
Clinic, Dispensary		823 75.4%	124 35.6%		7 63.6%	954 54.8%
PHC			162 46.6%			162 9.3%
Hospital, Nursing Home		38 3.5%	46 13.2%		4 36.4%	88 5.1%
Chemist, Pharmacist		187 17.1%				187 10.7%
Any Other		5 .5%	1 .3%	81 100%		87 5.0%
No response						4 .2%
Total	205 100%			81 100%	11 100%	1741 100%

(Percentages are column percentages)

Table 5.16 Location of facilities where care was received by rural and urban women

	Rural		Urban		Total	
	Episodes	Facilities	Episodes	Facilities	Episodes	Facilities
Non-hospitalised	1041 49.7	1157 87.5	353 43.4	374 89.5	1394 47.9	1531 87.9
Hospitalised	19 .9	24 1.8	1 .1	1 .2	20 .7	25 1.4
Non hosp. & Hospitalised	5 .2	5 .4	3 .4	3 .7	8 .3	8 .5
Someone Else Got Medicine	127 6.1	134 10.1	38 4.7	39 9.3	165 5.7	173 9.9
No Response	3 .1	3 .2	1 .1	1 .2	4 .1	4 .2
Not treated	901 43.0		417 51.3		1318 45.3	
Total	**2096**	**1323**	**813**	**418**	**2909**	**1741**

(Percentages are column percentages)

Table 5.17 Type of facilities utilised by women of different socio economic class

Socio-economic class	Non worker unskilled			Formal sector unskilled			Formal sector skilled			Professionals and trade		
	Facility	*Percent of*		*Facility*	*Percent of*		*Facility*	*Percent of*		*Facility*	*Percent of*	
		Sub total	*Total*		*Sub total*	*Total*		*Sub total*	*Total*		*Sub total*	*Total*
Self care	42	*38.2*	12.3	66	*48.2*	13.3	72	*44.2*	11.3	27	*36.5*	10.2
Chemist	50	*45.5*	14.7	49	*35.8*	9.9	55	*33.7*	8.6	33	*44.6*	12.4
Trad. Practitioners	17	*15.5*	5	20	*14.6*	4	34	*20.9*	5.3	9	*12.2*	3.4
Care by unqual.prac.	1	*0.91*	0.3	2	*1.5*	0.4	2	*1.2*	0.3	5	*6.8*	1.9
Sub total	**110**		**32.3**	**137**		**27.7**	**163**		**25.5**	**74**		**27.8**
Care by pvt. doctor	170	*73.6*	49.9	229	*64*	46.3	339	*71.2*	53.1	155	*80.7*	58.3
Care by govt. doctor	35	*15.2*	10.3	63	*17.6*	12.7	78	*16.4*	12.2	22	*11.5*	8.3
Care by govt. paramedic	22	*9.5*	6.5	64	*17.9*	12.9	53	*11.1*	8.3	11	*5.73*	4.1
NGO, Company, any other	2	*0.9*	0.6	2	*0.6*	0.4	5	*1.1*	0.8	3	*1.56*	1.1
Sub Total	**229**		**67.2**	**358**		**72.3**	**475**		**74.3**	**191**		**71.8**
No response	2	*0.9*	0.6		*0*		1	*0.2*	0.2	1	*0.52*	0.4
Total	**231**		**100**	**358**		**100**	**476**		**100**	**192**		**100**

Table 5.18 Type of treatment received in the different types of facility

	Home Care	Private	Public	Religious Traditio. Indigen.	NGOs, Company Any Oth	No response	Total
H.Remedy Self Medi.	199 97.1%	192 17.6%		79 97.5%			470 27.1%
Examin. Prescript'		87 8.0%	23 6.6%		2 18.2%		112 6.4%
Dispensed Medicine	1 0.5%	112 10.3%	175 50.4%	1 1.2%	8 72.7%		297 17.1%
Injections		588 54.0%	103 29.7%	1 1.2%			692 39.8%
Saline & Path.Tests		51 4.7%	16 4.6%				67 3.9%
Special Procedure	5 2.4%	40 3.7%	27 7.8%		1 9.1%		73 4.2%
Surgery/ Hospital'n		19 1.7%	3 0.9%				22 1.3%
No Response						4 100%	4 0.2%

(Percentages are column percentages)

Table 5.19: The rate of treatment per each type of illness reported by women

Type of illness	Treated episodes	Total episodes	Rate of treatment	No of formal facilities used per 100 episodes
Mental stress	10	48	20.8	8
Reproductive	177	580	30.5	22
Weakness	90	260	34.6	27
Sense organs	139	315	44.1	17
Aches/pain	257	520	49.4	32
Others	54	102	52.9	36
Injury/boil/burn	27	43	62.8	37
Respiratory	265	360	73.6	58
GIT	143	188	76.1	68
Fevers	429	493	87.0	89
Total	**1591**	**2909**	**55.0**	**43**

Table 5.20. Type of health facility utilised by type of illness (for women)

	Self care	Chemist	Private unqualified	Trad. Practitioner	Private Doctor	Govt. Doctor	Govt paramedic	NGO, Company		
	Informal				Formal				N.Res	Total
Reproductive	31	12		11	95	18	14	2	1	184
Percent	16.8	6.5		6	51.6	9.8	7.6			100
GIT	13	8	1	6	79	26	20	3		156
Percent	8.3	5.1	0.6	3.8	50.6	16.7	12.8	1.9		100
Weakness	12	4		8	52	13	5	1		95
Percent	12.6	4.2		8.4	54.7	13.7	5.3	1.1		100
Aches/pain	53	37	2	16	118	26	22	1	1	276
Percent	19.2	13.4	0.7	5.8	42.8	9.4	8	0.4	0.4	100
Fevers	10	21	4	10	310	69	56	4	1	485
Percent	2.1	4.3	0.8	2.1	63.9	14.2	11.5	0.8	0.2	100
Respiratory	38	38	2	4	154	29	24	1	1	291
Percent	13.1	13.1	0.7	1.4	52.9	10	8.2	0.3	0.3	100
Sense organs	31	57	1	6	38	10	6			149
Percent	20.8	38.3	0.7	4	25.5	6.7	4			100
Injur.boil.brn	12	3			10	4	2			31
Percent	38.7	9.7			32.3	12.9	6.5			100
Mental stress	2			5	3	1				11
Percent	18.2			45.5	27.3	9.1	0			100
Others	5	7		14	34	2	1			63
Percent	7.9	11.1		22.2	54	3.2	1.6			100

(Percentages are row percentages)

Table 5.21 Perceived efficacy of treatment recorded with use of each facility

	No effect		Partially better		Completely cured	
	Count	Row %	Count	Row %	Count	Row %
Type of morbidity						
Reproductive	52	30.8	54	32.0	63	37.3
GIT	38	25.5	26	17.4	85	57.0
Weakness	36	40.4	23	25.8	30	33.7
Aches/pain	98	37.5	76	29.1	87	33.3
Fevers	75	16.1	47	10.1	345	73.9
Respiratory	80	28.4	64	22.7	138	48.9
Sense organs	45	31.3	29	20.1	70	48.6
Injury/boil/burn	11	35.5	4	12.9	16	51.6
Mental stress	5	45.5	2	18.2	4	36.4
Others	23	41.8	11	20.0	21	38.2
Type of facility						
Self care	80	40.2	47	23.6	72	36.2
Chemist	47	25.5	36	19.6	101	54.9
Trad. Practitioners	25	33.8	17	23.0	32	43.2
Care by unqualified pr.	3	30.0	3	30.0	4	40.0
Informal care	**155**	**33.2**	**103**	**22.1**	**209**	**44.8**
Care by pvt. Doctor	210	24.7	168	19.8	472	55.5
Care by govt. doctor	55	29.1	34	18.0	100	52.9
Care by govt. paramedic	39	27.9	31	22.1	70	50.0
NGO, Company, Other	4	33.3			8	66.7
Formal care	**308**	**25.9**	**233**	**19.6**	**650**	**54.6**
Duration of illness						
0-28 days	192	19.6	126	12.9	662	67.6
29-365 days	120	41.5	74	25.6	95	32.9
1 to10 years	124	42.9	99	34.3	66	22.8
More than 10 years	20	32.8	28	45.9	13	21.3
No response	7	17.9	9	23.1	23	59.0
Total	**463**	**27.9**	**336**	**20.3**	**859**	**51.8**

Missing cases = 83

Table 5.22 Reasons for not seeking treatment stated by women in rural and urban areas

Reason For Not Seeking Treatment	Rural		Urban		Total	
	Episodes		Episodes		Episodes	
No Reason Given	7	0.8	3	0.7	10	0.8
Does Not Know	6	0.7	4	1.0	10	0.8
Will Be Going	39	4.3	15	3.6	54	4.1
No Response	41	4.6	3	0.7	44	3.3
	93	**10.3**	**25**	**6.0**	**118**	**9.0**
Services Are Far Away	6	0.7			6	0.5
No H F Available Close To The Village	5	0.6			5	0.4
Services Are Not Good, No Impact On Illness	86	9.5	40	9.6	126	9.6
Some Other Problems In Using H F	8	0.9	3	0.7	11	0.8
Doctor Unable To Cure	1	0.1	1	0.2	2	0.2
Does Not Like To Take Medicines	7	0.8	6	1.4	13	1.0
	113	**12.5**	**50**	**12.0**	**163**	**12.4**
Services Available But Financial Prob.	11	1.2	2	0.5	13	1.0
Financial Problems	301	33.4	128	30.7	429	32.5
No Time Free From Work	46	5.1	36	8.6	82	6.2
	358	**39.7**	**166**	**39.8**	**524**	**39.8**
Wrong Perception	3	0.3	1	0.2	4	0.3
Did Not Feel The Need, Illness Not Serious	146	16.2	79	18.9	225	17.1
Seasonal Illness	1	0.1	1	0.2	2	0.2
Linked To Menstrual Cycle	10	1.1	10	2.4	20	1.5
Chronic, Long Duration	42	4.7	11	2.6	53	4.0
Illness Due To Other Reasons	2	0.2			2	0.2
	204	**22.6**	**102**	**24.5**	**306**	**23.2**
Felt Shy Or Fearful	69	7.7	43	10.3	112	8.5
No Support From The Family	10	1.1	5	1.2	15	1.1
	79	**8.8**	**48**	**11.4**	**127**	**9.6**
Any Other	**54**	**6.0**	**26**	**6.2**	**80**	**6.1**
	901		**417**		**1318**	

6. Expenditure on Health Care

This chapter analyses the expenditure incurred by households as a unit, on illness affecting all family members. Expenditure has been examined in relation to costs incurred for individuals, episodes of illnesses and facility used. Also, examined are the various components of the costs incurred, differentials in expenditure due to various factors and utilisation of the health facilities. The analysis of expenditures incurred on women has been done separately.

The study is unique since it interviewed only women of a household and women investigators conducted interviews. Further, it made use of a probe list of various symptoms to record illness affecting women. The recording of expenditure on illness was for a recall period of one month. Efforts were made to record expenditures incurred by various components of health care costs. A major emphasis was to record the gender issue in terms of the problems women experience and the differentials that exist in the spending patterns of households.

Overall patterns

The health expenditure incurred by the total sample in the reference period amounted to 3,76,369 rupees (Table 6.1). Calculated as per capita expenditure it amounted to 52 rupees per month; therefore, the annual per capita expenditure is Rs. 624. This amount does not include expenditure on maternity events and contraception (discussed in the next chapter).

The rural per capita expenditure was higher by 20 per cent than urban. There was also a similar difference in the per episode expenditure, where the rural and urban expenditure was Rs. 97 and 78 respectively. However, the per-facility (total) expenditure in the rural and urban households is more similar, being Rs. 148 and 139 for rural and urban respectively.

Further analysis of facility-wise expenditure reveals that **the cost of care, for both inpatient and outpatient facilities in urban areas was higher than in rural areas. This is largely due to the lower use of public facilities in urban areas. However, since the rate of hospitalisation was higher in rural areas, their overall expenditure incurred on health care was much higher.** Quite predictably, for both rural and urban households, there was a vast difference in the expenditure on inpatient and outpatient care, with the former being enormously high.

Similarly, there was a significant difference in the expenditure incurred on formal and informal facilities. Expenditure by urban women on informal facilities recorded the lowest — they spent only Rs. 24 per facility. That overall reduction in expenditure is made possible by the use of informal facilities is evident from this table. However, whether this use of facilities is out of choice or due to absence of affordable formal health care is an important question. **The high use of informal care also contributes to the significantly lower expenditure on women as compared to men. It is also important to note that the expenditure on each type of facility was higher for men than for women and on rural women than on urban women.**

Expenditure on health can be examined broadly under various components of costs incurred on treating the illness: two types, namely expenditure incurred *directly* for the provision of health care services and *indirect* expenses incurred to access these services. The main components of direct expenditures are payment made to the doctor, expenditure incurred on medicines, investigations carried out for diagnosis, expenditure on surgery and charges for hospitalisation. Indirect costs would include expenditure on special diet for illness or events, travel to the facility, bribes and tips paid, costs on gifts given and rituals performed. An effort was made to record separately, the expenditure on each component. However, it was often difficult for respondents to provide a break-up of expenditure on each component. This was particularly true in the case of inpatient care where the hospital bills included the costs of hospitalisation, practitioners' fees and

medicines. Even in the case of outpatient care, in many cases the respondent was not able to provide the break-up of expenditure. A very common combination of expenditure was on fees and medicines. As seen in the previous chapter, general practitioners usually dispensed medicines or administered injections together with an examination.

An analysis of expenditure on the different components in the facilities (Table 6.3) showed certain marked differences in rural and urban statistics. For women in urban households, 93 per cent of the total expenditure was spent directly on accessing health services. In general, 70.3 per cent of the total expenditure was incurred on fees, medicines, investigations and hospital services. However, among women in urban households the expenditure on medicines is higher due to the higher incidence of self-medication. Also 30.1 per cent of the total expenditure in urban households was incurred on investigations. This is remarkable considering that the use of investigations was lower in the urban areas. The explanation for this may be that while more than one third of the investigations in rural areas were conducted in government facilities, all the investigations in urban areas were conducted in the private sector. Predictably, we find that a higher percentage of the expenditure was incurred on travel by rural than by urban households.

Fees constituted a lower proportion of expenditure on women as compared to men. This is also a result of the lower use of formal care by women. Among the general practitioners, the fees charged are not just for consultation but also for the medicines and injections that the doctor provides. The expenditure incurred on such combinations was recorded separately. Combining the expenditure on doctor's fees, medicines and injections accounted for 48 per cent of the total expenditure. This accounted for the major proportion of the expenditure on outpatient care. Hospitalisation, though rare, accounts for a significant proportion of the expenditure on health, especially in rural areas. For rural males, one fourth of the total expenditure was incurred directly on hospital care and surgery. Apart from this combined direct/indirect costs on inpatient care constitute 40 per cent of the total expenditure. Indirect expenditure on components other than travel is negligible.

Expenditure by type of morbidity

There was a remarkable similarity in the expenditure on the different types of illnesses in rural and urban areas. (Table 6.6) In general, the expenditure on each episode of fever was Rs. 74. While gastro-intestinal illnesses were the most expensive to treat, with an average expenditure of Rs.119 per episode, the expenditure on each respiratory illness episode was on an average Rs. 83. The expenditure on infectious illness was high — this corresponds with the finding that treatment rate for these illnesses is high and also that there is high use of formal care for these illnesses.

Expenditure on the category of 'other illnesses' — cardio-vascular and circulatory problems – was also considerably high. Not surprisingly, per episode expenditure is low for illnesses that are not frequently treated. This group included the three categories of problems most frequently reported among women — reproductive problems, weakness, aches and pains. For injuries that were frequently treated, but largely using informal services, the per episode expenditure was the lowest, being Rs. 24 per episode. For sense organ problems, which were also frequently left untreated, the per-episode expenditure was low. The high expenditure on mental stress in the rural sample is misleading and on account of only one exceptional case.

The distribution of expenditure across the various types of morbidity indicates that significant proportions of household resources were spent on fevers in rural areas and respiratory illnesses in urban areas. A different trend is observed among urban women where treatment of aches and pains and reproductive illnesses consumed a sizeable proportion of the household resources.

Expenditure with utilisation

The analysis of expenditure with episode expenditure or per capita expenditure hides the true picture of

the expenditure patterns and trends. As seen earlier, a large proportion of the episodes did not use any health facility. Therefore, this analysis is restricted to expenditures incurred by those who had used health facilities for treatment of their illness, taking into account illnesses that were treated at home.

It was clear that the major expenditure incurred by the sample households was on private facilities (Table 6.5) Out of a total expenditure of Rs. 3,76,369, Rs. 341510 was spent on private facilities – a whopping 90 per cent. While, the expenditure on private facilities in rural areas was Rs. 118 per facility, it was Rs. 128 in urban areas. However, in both, there is a significant difference in the expenditure on private and public facilities. In both rural and urban areas, the expenditure on private facilities was more than ten times that on public facilities. Expectedly, the expenditure on home remedies is extremely low.

The use of religious, traditional indigenous practitioners is high in the rural areas — expenditure on them is considerably high (Rs. 101). For inpatient care, the expenditure in public facilities in urban areas is much higher than that in rural areas. However, as very few cases of inpatient care have been recorded, a comparison is difficult. However, expenditure on inpatient care in public facilities was more than $1/3^{rd}$ that on private facilities. This indicates that the use of public facilities for inpatient care also involves substantial household financing.

The disaggregation of direct and indirect costs revealed very interesting facts (Table 6.4). In outpatient care, there was negligible difference in the indirect expenditure incurred for accessing public and private facilities. However, there was a sharp difference in the indirect costs incurred for accessing inpatient care from public and private facilities. These indirect costs accounted for more than half the total expenditure on the facility while indirect costs for accessing private inpatient facilities was negligible.

Expenditure on health care by men

It was considerably higher than the expenditure on women (Table 6.3) Though the morbidity recorded for men was considerably lower than that for women, the per capita expenditure on men was Rs. 56 per month compared to Rs. 48 per month for women. The per facility expenditure for men was reported to be Rs. 206; this was lower for rural than for urban men. Also, the per facility expenditure for outpatient care for rural men was Rs 91, it was Rs. 146 for urban men. This is because the use of public services among rural men is high. Thus, in spite of the fact that they use more formal care, the expenditure per facility for rural men does not increase. The inpatient care expenditure for rural men was also lower than that for urban men; also, expenditure in both formal and informal facilities was lower for rural than for urban men.

Expenditure incurred on women

Since the study focused on women, expenditure patterns for women were analysed separately. Access for women to health care services is determined by various factors that exist within and outside the household. **The expenditure incurred per episode without probing was Rs. 116 and with probing Rs. 28.** The pattern was similar in both urban and rural areas. This clearly reveals that **majority of the women do not perceive certain type of illnesses as illness and only after probing report them and further do not utilise health facilities for treating the illness or use informal care.**

Expenditure on women assumes more significance when we examine it in terms of different characteristics of the household — location of the household that determines access to health care facilities, the size of the family and type, caste and socio-economic class. (Table 6.7)

Access

Households based on their location were categorised into those with easy access, difficult access and those in remote areas. In remote areas, the women were at a great disadvantage as the availability of health

services was restricted. These women had a total of 199 illness episodes for which the episode cost worked out to Rs 50 and the per-facility cost was Rs 88. Together with a high rate of untreated illnesses, women in remote rural households spent very little on health care. This is evidence of the neglect of their health problems. They reported low morbidity, they reported low rates of utilisation of health care and expenditure, their per episode expenditure is also the lowest. There was not much difference in terms of expenditure of women with easy and difficult access. However, as access becomes easier, the health expenditure goes up. It is clear that if health facilities are easily accessible women will reach out for treatment. Similarly, there is only a marginal difference in the per facility expenditure incurred on women living in the urban slum and non-slum localities. However, the difference in per episode expenditure is considerable which showed that despite morbidity being considerably higher among slum women their utilisation of health care was much lower. The fact that per capita expenditure is similar indicates the heavy burden that health care imposes on poor households as they have to spend a larger proportion of their income of health care.

Composition of the household

The number of family members in the household has a significant role on the expenditure incurred on women. **Those with a smaller family size spend more than those with larger families. As the size of the family increases, the expenditure on treatment of women decreases.** Only in the category of those with above 15 persons, the expenditure was higher in terms of episode and facility used cost. This trend is reversed for the other categories. Considering that morbidity was lower for women in larger households, while utilisation was higher, the lower expenditure is puzzling. While it is possible that larger households sought more economical health care, it remains to be seen whether the effect of proxy reporting distorted information in this respect.

Along with the family size, the type of the family also mattered. This refers to whether the family was original settled or migrant. Many households migrate in search of work – either the entire family or only the earning members. Migration places a heavy burden on the households, especially women, as they have no regular source of income. Further, it places them in a different surrounding. The study found that the **women from migrating households were spending very less on health care – only Rs. 28 per capita. Their expenditure per episode was Rs. 30 and per facility was Rs. 63. Lower expenditure among migrants is seen among both rural and urban women.** This complements the findings that morbidity is high among this group while non-treatment of illnesses is high.

Caste/community

As with morbidity and utilisation, we find that the caste/community status of the women is a significant variable in expenditure on health care. Women of the upper caste had the highest expenditure on health, per facility expenditure being Rs. 140. Women from the farming and artisan community were spending Rs. 115 per facility as compared to women from schedule caste and scheduled tribes who spent Rs. 64 and Rs. 81 per facility respectively. In general, **women from the lower castes and tribals were spending just half the amount that was being spent by upper caste.** This low expenditure points to the lack of access to health care. This complements the finding that use of health care, particularly formal facilities, by scheduled caste women was very low. For scheduled tribe women, the reporting of morbidity is relatively low, the use of health care is even lower and, hence, the expenditure reported was considerably lower than average. The low per capita and per facility expenditure by urban upper caste women is surprising, considering the fact that the use of formal facilities by them is high.

Socio economic class

The co-relation between socio-economic class and expenditure is not very distinct (Table 6.8). In general, there was a significant difference in the expenditure incurred on women of the lowest class

and the highest class. However, there was no steady progression in the expenditure with the rise in socio-economic class. Considering only the expenditure on outpatient facilities, there was a distinct relationship in the rural households — the expenditure increased from Rs. 55 for women of the lowest socio-economic class to Rs. 132 for the highest socio-economic class. In urban areas, such a co-relation was not visible.

Life stage

The highest expenditure incurred was on women who were above 56 years and the lowest on those below 4 years of age across the various costs. (Table 6.8) The low cost of care for infant girls may be due to the fact that their illnesses are mostly of short duration and predominated by 'fevers.' The patterns of expenditure by age characteristics revealed that **the expenditure on women increases with a rise in the age. The expenditure declines in the age category of 46-55 years but again increases after 56 years.**

The majority of illness episodes (655) affected women in the age group of 26-35 years; however, they had a very low expenditure of Rs. 47 only per episode. For women in the reproductive age of 12-45 years the average episode expenditure was Rs. 40 and for those who used facilities it was Rs. 90. Within the reproductive age group, the highest expenditure was on women in the age group of 36-45 years. Regarding the rural- urban difference, the expenditure was higher in urban than rural areas only in the age group of 5-11 years. The expenditure between rural and urban areas was strikingly wide for women in the age groups of 12-17 years and above 56 years.

Earning status

The expenditure was highest among the different categories of house-workers: the per episode expenditure was Rs. 48, per capita Rs. 85 and per facility expenditure was Rs. 152. The expenditure on non-working women in terms of per capita and per facility used was the lowest. However, their use of health care was the highest as was their use of formal care. Non-workers are concentrated at the extremes of the age spectrum. Thus, the young girls' illnesses were treated often but without much expenditure as explained above. The true comparison is between house-workers and earning women, where the study found that least is spent on the latter. Hence, **though illness was equally prevalent among house-workers and earners, and their health care utilisation pattern is similar, the actual expenditure on earning women is much lower.**

Education

There was no co-relation of expenditure with educational status of adult women (Table 6.9). The highest expenditure is recorded for women with secondary education, while the lowest for those with higher secondary education.

To understand expenditure more fully, it was studied in terms of gender characteristics: martial status, number of living children, relationship to the head of the household and number of women in the family.

Marital status

The martial status of women was an important determinant. **Women who were not married were spending only Rs. 15 per capita compared to per capita expenditure on all women in the sample of Rs. 48 (Table 6.9)** A similar pattern was found in terms of per episode cost and those who used a health facility. The expenditure incurred on the never married women was very low. The difference between the currently married women and never married women in terms of facility cost and per capita cost was quite vast. The highest expenditure was incurred on women who were currently married, taking all costs into consideration. There was not much difference in rural and urban areas. Thus, ever-married single women who suffer do not receive the same opportunities as currently married women for health care. The lower expenditure on them can be explained by the fact that their illnesses are less often treated; also the use of informal facilities is high among them.

Number of children

No specific pattern was visible in the expenditure on women vis-à-vis the number of living children they had. In general, the pattern was a reflection of expenditure for the age group of women who predominate each group. There is very low per capita and per episode expenditure on women who have upto two children. As women with more children are more likely to be older, the expenditure on them rises. The low expenditure on women who are not yet married is explained by the fact that all of them are young girls. There was also very marginal difference in the per facility expenditure for women in all the groups.

Expenditure and type of illness

When women fall ill, not all their illnesses are treated. Expenditure provides an indication of the importance given to women (Table 6.10) in terms of the number of episodes for women in various categories compared to incurred expenditure. Women suffering from gastro-intestinal illness, fevers, respiratory illness and injuries/burns were treated. In the other categories of illness, less than one-third of the episodes were treated. Hence, there was a wide variation in the per episode cost incurred on the different of types of illnesses. The illnesses that were most often treated had the highest per episode cost. When the actual expenditure incurred on treating an illness at a health facility is studied, the trends were reversed. The expenditure per facility on fevers was relatively low as compared to reproductive illness. GIT and respiratory problems had high per facility cost because the administration of saline was quite common in the former category while the treatment for the latter is long-term. The cost per facility of treating 'other illnesses' was very high because this included cardio-vascular problems and a few cases of hospitalisation and surgery. The expenditure was more in rural areas as compared to urban areas in most of the categories of illness except in weakness and injuries/burns where the expenditure in urban was more than in rural areas.

Examining the distribution of expenditure across various types of illness (Table 6.6), showed that in rural areas, fevers and respiratory illnesses alone accounted for half of the total health expenditure incurred on women while GIT problems accounted for 16.7 per cent. In urban areas, a considerable amount of expenditure was on gender-related illnesses, reproductive problems, weakness and aches/pains. However, the largest proportion of the expenditure was incurred on respiratory illnesses — 26.6 per cent.

Expenditure by type of facility

Cost incurred on facilities according to their type (Table 6.11) showed that **the highest expenditure was on formal private facilities as represented by the care of private doctors. The cost incurred on self-care and self-medication is less.** However, it is interesting to note that the cost of self-medication (chemist) was much higher in rural than urban households probably because chemist shops were concentrated in the urban areas. The cost of using public health care was low though not free. Apart from the cost of transport, many of the drugs were prescribed and were bought. The cost of using informal care was less than half of formal care.

The location of the health facility was another major determining factor in its utilisation (Table 6.12) For rural women there was a consistent increase in cost with an increase in the distance travelled. While the per facility cost of treatment was Rs. 91 when the facility was in their own village, it increased to Rs. 102 when they had to travel to a neighbouring village and further to Rs. 122 when they went to a neighbouring town. Not surprisingly, the cost of treatment per facility for rural women in Nashik was very high Rs. 336. Considering that only half of the facilities used by rural women were in their village, they bore the additional cost merely because health facilities were inequitably distributed.

Expenditure by duration of illness

The duration of illness showed a significant co-

relation with expenditure (Table 6.13). **Short-term episodes had higher expenditure than those of longer duration, primarily because the rate of treatment and the use of formal care are higher for short duration episodes.** As noted in the previous chapter, nearly 40 per cent of the facilities which were utilised in the treatment of episodes lasting longer than 10 years were informal facilities. Thus, the per episode expenditure on such illnesses is only Rs. 17 as compared to Rs. 64 spent on average on the treatment of episodes having a duration of four weeks or less.

Expenditure by type of treatment

There emerged a distinct pattern when expenditure incurred per facility was compared with the type of treatment (Table 6.14) **In a very high number of cases, women resorted to home remedies and self-medication which had a mean facility cost of Rs.29.** The high cost of treatment per facility where there was no dispensing can be accounted for by the fact that consultants charge considerably higher fees for services than general practitioners. A very high proportion of illness was treated with injections. In 692 cases, women were treated by injections incurring an expenditure of Rs. 77 per facility cost, compared to Rs. 24 per facility cost when no injections are given. The number of cases where women were treated by injections was higher in rural than urban areas. The rampant use of injections in treating illness is of utmost concern as is the deliberate attempts being made to convince people that injections are more effective than medicines.

The common practice of administering saline to diarrhoea patients or even fever patients resulted in high expenditure. The average cost per facility where such service was received was Rs. 188. The use of saline entails a very high expenditure and its use along with injections needs to be questioned.

There was a vast difference in the cost incurred on pathological tests in rural and urban areas, perhaps because public facilities were used more often in rural areas. The main use of these tests was to diagnose malaria. Also, the cost of hospitalisation and surgery was very high, especially for rural women, mainly because the duration of hospitalisation was longer as well as the high indirect costs involved in transport and accommodation of carers.

Conclusion

A major finding is the high and increasing cost of healthcare in household expenditure.

Expenditure on health care by men is significantly higher than the expenditure by women.

While expenditure on inpatient and outpatient facilities is marginally lower in the rural areas, the overall expenditure incurred per facility by rural households is higher due to the higher use of inpatient care. As health facilities are located at a considerable distance from the village, they are compelled to hospitalise the sick person.

Expenditure incurred by urban women is lower than that incurred by rural women.

Expenditure among women is determined by various social factors — women belonging to the scheduled castes and tribes spend much less on health care than upper caste women.

The treatment of chronic illnesses of women is infrequent and the expenditure is low, also there is high use of informal care for such problems. Women learn to use self medication and self care to lower expenditure on long term illnesses for which more expensive formal care has proved inadequate or ineffective.

Also, there is considerable difference in the expenditure on inpatient and outpatient care with per facility expenditure for the former being more than ten times. The difference between the expenditure on private health care and public health care is considerable, though expenditure

on inpatient care in the public sector is also significant. However, the importance of public facilities in providing inpatient care, in particular, cannot be overstated This high expense is often met by cutting on consumption of other services and/or by incurring debt.

Also, younger women spend less on health care than older women. The rate of morbidity and the rate of treatment alone do not determine expenditure as can be seen for young girls, whose illnesses are treated more often but with little expense. This is also because the treatment of certain types of illnesses is done with less expense than others. However, **distribution of health expenditure shows that in rural areas, it is concentrated on the treatment of GIT, respiratory and (fever) infection related problems while in urban areas, respiratory illnesses, reproductive problems and weakness/aches and pain claim a large share of health expenditure on women.**

Table 6.1: Overall Expenditure among rural and urban households

	Total		Male		Female	
Total Expenditure Incurred (Rs.)	**3,76,369**		**203962**		**172407**	
Rural	2,91,556		149609		141947	
Urban	84,813		54353		30460	
Number Of Persons	**7212**		**3631**		**3581**	
Rural	5305		2662		2643	
Urban	1907		969		938	
Average Exp. Per Capita (Monthly) (Rs.)	**52**		**56**		**48**	
Rural	55		56		54	
Urban	44		56		32	
Average Exp. Per Capita (Yearly) (Rs.)	**624**		**672**		**578**	
Rural	660		672		644	
Urban	528		672		390	
Number Of Episodes	**4109**		**1200**		**2909**	
Rural	3019		923		2096	
Urban	1090		277		813	
Average Exp. Per Episode (Rs.)	**92**		**170**		**59**	
Rural	97		162		68	
Urban	78		196		37	
No. Of Episodes where payment made	**1740**		**693**		**1155**	
Rural	1310		527		866	
Urban	430		166		289	
Average Exp. per paid Episode (Rs.)	**216**		**294**		**149**	
Rural	222		284		164	
Urban	197		327		105	
Number Of Health Facilities Utilised*	**2828**		**1087**		**1741**	
(outpatient/inpatient)	**2744**	**73**	**1040**	**40**	**1704**	**33**
Rural	2103	63	812	34	1291	29
Urban	641	10	228	6	413	4
Average Exp. Per Facility – Total (Rs.)	**146**		**206**		**99**	
Rural	148		193		107	
Urban	139	254	73			
Average Exp. Per outpat./inpat.* Facility (Rs.)	**86**	**1930**	**103**	**2422**	**75**	**1334**
Rural	83	1853	91	2234	78	1407
Urban	95	2414	146	3488	66	805
No. of facilities utilised (form./inform.)#	**2104**	**713**	**851**	**229**	**1253**	**484**
Rural	1705	461	695	151	1010	310
Urban	399	252	156	78	243	174
Average Exp. Per formal/informal facility (Rs.)	**164**	**42**	**220**	**72**	**127**	**28**
Rural	160	39	203	57	131	30
Urban	182	48	298	101	108	24

Note: The inpatient/ outpatient status of 11 facilities was not known # The formal/ informal status of 11 facilities was not known*

Table 6.2 The per facility cost for inpatient and outpatient facilities

	Where there are combined costs		Where there are no combined costs	
	Per facility Exp.	Facilities	Per facility Exp.	Facilities
For Entire Population	324	622	79	2195
Outpatient	**125**	**574**	**75**	**2170**
Home	66	2	2	281
Private	127	556	118	1233
Public	77	16	14	529
Religious			57	97
Traditional, Untrained Pract.			367	11
Company			35	9
N.G.O			1	7
Any Other			1	3
Inpatient	**2710**	**48**	**433**	**25**
Private	2882	41	544	15
Public	1705	7	335	8
Company			0	2

Table 6.3: Expenditure incurred on components of costs as percentage to total costs .

	Rural		Urban		Total
	Male	Female	Male	Female	
Fees	8.0	12.7	4.8	12.6	9.7
Medicines	21.6	29.6	28.5	33.7	26.6
Investigations	4.6	0.9	12.9	25.8	6.1
Fees. medicines and investigations combined	8.7	18.0	8.4	15.1	12.7
Surgery	1.3	0.00	0.0	0.0	0.5
Hospitalisation	0.9	0.5	0.07	0.0	0.6
Direct costs related to hospitalisation	22.8	12.0	0.9	5.4	14.2
Direct and indirect costs related to inpatient care	22.3	17.1	37.0	0.0	20.6
Direct and indirect costs related to outpatient care	2.3	0.7	0.1	0.0	1.2
Diet	1.5	1.0	3.4	2.8	1.7
Gifts and bribes	0.01	0.0	0.0	0.01	0.01
Other expenses	0.5	0.0	0.1	0.1	0.2
Rituals	1.2	1.9	3.0	0.6	1.7
Travel	4.3	5.7	0.8	3.9	4.3
Total costs	100.0	100.0	100.0	100.0	100.0

Table 6.4: Per facility cost for facilities where no costs are combined

Type of ownership	Per Facility Direct Cost	Per Facility Indirect Cost	Number Of Facilities
Total	**70**	**9**	**2195**
Outpatient	**67**	**8**	**2170**
Home	2	0	281
Private	109	9	1233
Public	10	4	529
Non Governmental	0	1	7
Company	35	0	9
Religious	3	55	97
Traditional, Untrained	365	2	11
Any Other	1	0	3
Inpatient	**357**	**76**	**25**
Private	522	22	15
Public	137	198	8
Company	0	0	2

Table 6.5: Per facility expenditure for each type of facility

Type of health facility	Rural		Urban		Total	
Outpatient Care	Exp. (Rs)	Facility	Exp. (Rs)	Facility	Exp. (Rs)	Facility
Home care	2	187	3	96	2	283
Private	118	1331	128	459	121	1790
Public	16	486	12	58	16	544
Religious, Traditional, Indigenous	101	89	34	19	89	108
Any other (NGO, company)	2	10	34	9	17	19
Inpatient Care						
Private	2188	52	3129	4	2255	56
Public	332	9	1938	6	974	15
NGO, Company, Any other	0	2			0	2

Note: The type of facility was not known for 11 facilities

Table 6.6 Expenditure by type of illness in rural and urban households (in Rs)

	Rural male	Rural female	**Rural**	Urban male	Urban female	**Urban**	**Total**
	Percent of total exp.		Per episode exp. (Rs.)	Percent of total exp.		Per episode exp. (Rs.)	Per episode exp. (Rs.)
Reproductive	0.6	12.7	**25**	0.0	17.9	**26**	**25**
GIT	19.6	16.7	**104**	20.3	9.1	**168**	**119**
Weakness	0.8	2.2	**23**	0.3	9.8	**34**	**27**
Aches/pain	1.8	6.9	**25**	3.8	13.9	**33**	**28**
Fevers	40.8	22.7	**74**	7.6	7.9	**73**	**74**
Respiratory	25.5	19.2	**88**	26.6	26.6	**73**	**83**
Sense organs	4.0	5.3	**37**	4.3	2.1	**32**	**36**
Injury/boil/burn	0.3	0.2	**20**	1.7	2.1	**28**	**24**
Mental stress	1.9	0.0	**99**	0.0	0.4	**6**	**60**
Others	4.7	14.1	**92**	23.2	10.3	**92**	**92**
Total	100.0	100.0	**58**	100.0	100.0	**56**	**57**

Table 6.7: Expenditure for women (in Rs.)

	Per episode cost	**Per capita cost**	**Per facility cost**
Access			
Rural Easy Access	74	57	113
Rural Difficult Access	65	55	105
Rural Remote	50	35	88
Urban Non slum	51	34	80
Urban Slum	34	32	71
Size of the Family			
1-5 persons	**61**	**62**	**108**
Rural	74	78	125
Urban	39	36	75
6-10 persons	**59**	**46**	**99**
Rural	67	51	105
Urban	38	32	75
11-15 persons	**44**	**31**	**67**
Rural	54	33	71
Urban	16	11	30
15 & more	**70**	**31**	**128**
Rural	70	31	128

Duration of settlement			
Original/old settler	**59**	**55**	**111**
Rural	60	55	111
Urban	56	48	113
All year migrants,	**30**	**28**	**63**
Rural	27	27	44
Urban	31	28	68
Others	**27**	**27**	**48**
Rural	40	36	85
Urban	22	24	37
Caste/community of the household			
Upper castes	**85**	**68**	**140**
Rural	96	81	159
Urban	43	29	69
Other Hindu castes	**77**	**65**	**115**
Rural	81	65	117
Urban	64	64	110
Scheduled castes	**33**	**29**	**64**
Rural	44	42	73
Urban	21	18	51
Scheduled tribes	**48**	**36**	**81**
Rural	51	37	84
Urban	31	27	63
Muslims, Christian	**58**	**59**	**95**
Rural	102	107	126
Urban	41	41	76

Table 6.8: Expenditure for women (in Rs.)

Socio-economic class of the household			
	Per episode cost	Per capita cost	Per Facility cost
Non worker, unskilled	**31**	**33**	**68**
Rural	27	31	59
Urban	35	35	80
Formal sec.unskilled	**40**	**35**	**70**
Rural	47	41	79
Urban	21	19	42
Formal sector / skilled	**70**	**59**	**125**
Rural	72	60	128
Urban	54	50	97
Professionals, traders	**64**	**66**	**130**
Rural	70	82	144
Urban	48	33	86
Age group			
Upto 4 years	**29**	**13**	**39**
Rural	29	13	39
Urban	29	12	37
5 – 11 years	**33**	**16**	**52**
Rural	30	17	53
Urban	41	13	46
12 – 17 years	**60**	**29**	**92**
Rural	70	35	102
Urban	26	12	49
18 – 25 years	**48**	**42**	**92**
Rural	57	48	97
Urban	28	26	75
26 – 35 years	**47**	**70**	**107**
Rural	55	83	117
Urban	30	42	78
36 – 45 years	**54**	**93**	**121**
Rural	60	102	135
Urban	36	65	82
46 – 55 years	**46**	**72**	**99**
Rural	47	78	111
Urban	44	57	73
56 years and above	**102**	**137**	**191**

Rural	117	156	209
Urban	61	82	127
Earning status			
Non earners	**44**	**18**	**55**
Rural	50	21	59
Urban	29	12	40
House-workers	**77**	**85**	**152**
Rural	104	110	184
Urban	48	54	105
Earners	**56**	**59**	**100**
Rural	62	64	107
Urban	31	38	65

Table 6.9: Expenditure on women (in Rs.)

Educational level			
	Per episode cost	Per capita cost	Per Facility cost
Illiterate	**43**	**118**	**72**
Rural	45	125	76
Urban	35	91	58
Primary	**31**	**62**	**45**
Rural	31	46	39
Urban	30	113	56
Secondary	**99**	**169**	**105**
Rural	152	230	141
Urban	32	68	43
Higher secondary	**24**	**40**	**18**
Rural	30	39	20
Urban	22	40	17
College, tech, prof'nl	**60**	**92**	**29**
Rural	86	86	86
Urban	57	93	27
Marital status			
Never married	**33**	**15**	**49**
Rural	34	17	51
Urban	31	12	43
Currently married	**59**	**73**	**120**
Rural	68	82	131
Urban	34	47	85

Widowed, separated,	**45**	**74**	**110**
Rural	44	78	121
Urban	47	65	84
Number of living children			
No children	**69**	**60**	**136**
Rural	77	65	145
Urban	33	31	80
Upto 2 children	**35**	**38**	**71**
Rural	40	40	76
Urban	27	32	61
Upto 4 children	**62**	**95**	**132**
Rural	68	102	138
Urban	48	73	113
> 4 children	**67**	**108**	**146**
Rural	79	124	168
Urban	34	55	75
Not married	**33**	**15**	**49**
Rural	34	17	51
Urban	31	12	43
No Response	**2**	**2**	**5**
Rural	3	3	8
Urban	0	0	0

Table 6.10: Expenditure incurred on types of illness. (in Rs.)

	Per episode cost		Per facility cost	
	Expenditure	Episodes	Expenditure	Episodes
Reproductive	**40**	**580**	**127**	**184**
Rural	47	384	139	130
Urban	28	196	101	54
GIT	**141**	**188**	**170**	**156**
Rural	174	136	208	114
Urban	53	52	66	42
Weakness	**23**	**260**	**64**	**95**
Rural	18	173	45	68
Urban	34	87	110	27
Aches/pain	**27**	**520**	**51**	**276**
Rural	28	354	51	192
Urban	26	166	50	84
Fevers	**70**	**493**	**71**	**485**
Rural	71	452	72	445
Urban	59	41	60	40
Respiratory	**98**	**360**	**121**	**291**
Rural	117	232	147	185
Urban	63	128	76	106
Sense organ pr.	**26**	**315**	**55**	**149**
Rural	30	255	60	126
Urban	11	60	27	23
Injury/boil/burn	**22**	**43**	**31**	**31**
Rural	13	25	19	17
Urban	35	18	45	14
Mental stress	**3**	**48**	**13**	**11**
Rural	1	27	4	8
Urban	6	21	40	3
Others	**227**	**102**	**367**	**63**
Rural	344	58	526	38
Urban	72	44	126	25
Total	**59**	**2909**	**99**	**1741**
Rural	68	2096	107	1323
Urban	37	813	73	418

Table 6.11 Expenditure by type of facility

Type of facility	Rural		Urban		Total	
	Per fac exp.(Rs.)	No. of facilities	Per fac exp.(Rs.)	No. of facilities	Per fac exp.(Rs.)	No. of facilities
Self care	2	134	3	73	2	207
Chemist	72	100	43	87	59	187
Trad. Practitioners	26	66	9	14	23	80
Care by pvt. Doctor	180	698	127	195	169	893
Care by pvt. Unqual. Prac.	16	10	-	-	16	10
Care by govt. Doctor	25	177	41	21	27	198
Care by govt. Paramedic	15	129	21	21	15	150
Ngo, company, Any other	6	6	50	6	28	12
No response	8	3	0	1	6	4
Total	107	1323	73	418	99	1741

Table 6.12 Expenditure according to location of facility

	Rural		Urban		Total	
	Per fac exp.(Rs.)	No. of facilities	Per fac exp.(Rs.)	No. of facilities	Per fac exp.(Rs.)	No. of facilities
At home	8	182	7	77	8	259
Own Village	91	494	86	328	89	822
Other neighbouring village	102	255	27	7	100	262
Neighbour town, taluka place	122	287	287	5	122	287
Any other (Nashik, outside Nashik dist.)	336	102	0	1	334	107
No response	8	3			6	4
Total	107	1323	73	418	99	1741

Table 6.13: Per episode expenditure on women according to duration of episode

Duration of illness	Rural		Urban		Total	
	Per epi exp (Rs.)	No of epi.	Per epi exp (Rs.)	No of epi.	Per epi exp (Rs.)	No of epi.
0-28 days	69	929	46	231	64	1160
29-365 days	43	377	38	207	41	584
>1-10 yrs	31	568	21	302	28	870
>10 yrs	16	121	19	62	17	183
No response	10	100	94	11	18	111
Total	48	2095	34	813	44	2908

Table 6.14 Per facility expenditure according to type of treatment received.

(in Rs.)

	Rural		Urban		Total	
	Exp. (Rs.)	Facilities	Exp. (Rs.)	Facilities	Exp. (Rs.)	Facilities
Home remedy & self-medication	31	292	26	178	29	470
Examination & Prescription	222	69	175	43	204	112
Dispensed medicines	20	239	40	58	24	297
Injections	78	578	74	114	77	692
Saline	176	37	244	8	188	45
Pathological tests	101	18	474	4	168	22
Special procedures	253	65	171	8	243	73
Surgery /hospitalisation	2153	20	1031	2	2051	22
No response	8	3	0	1	6	4
Total	107	1321	73	416	99	1737

7. Maternity Events and Contraception

This study recorded information on maternity events and contraception use in the previous year. Though use of contraception by males was noted details were recorded only for female users. However, as only 1193 households participated in the study, the information on maternity events and contraceptive use is not substantial. Therefore, only a brief analysis has been attempted.

Maternity events, especially, contraception has too often been isolated from issues of women's health. Both these must be included in a study of women's health. If the final aim of health care services is to ensure the safety and health of women, it is important to study these events from the point of view of health.

Maternity events and contraception differ from morbidity in many significant ways. The degree to which these have been medicalised varies considerably from group to group. They are also important social events where the roles of the entire extended family are well defined. This phase of women's lives has also drawn considerable attention from the state: maternal health and family planning being the first (and only) women-centred mass health programme functioning in the country. Besides, the private sector has highly developed facilities specifically to provide services for these events. Even so, a large proportion of these events are managed by traditional, informal providers and collectively in the community itself. They are worth studying because, as observed in earlier chapters, these events have a long-term impact on women's lives and are integrally linked to their experience of illness and well being.

Obviously, maternity events are concentrated among women between 18 and 35 years (Table1). The mean age of women reporting an event is 24 years. The median age for pregnancy, abortion and deliveries is 22 years. However, a substantial number of the deliveries (11), pregnancies (10) and abortions (3) occurred among women below the age of 18 years. About 15 of these events were recorded in women above 35 years. **In general, childbearing commences early in adulthood for most women.** Though detailed reproductive history was not recorded, it was found **the mean age of pregnant women, in a first-time pregnancy, was 18.6 years.** The age of the oldest woman who had a delivery in the reference period was 40 years.

Expectedly, the greater part of the burden of contraception was also borne by women. 44.6 per cent of the currently cohabiting women between 26-35 years had undergone sterilisation previously. Another 5.1 per cent were using other methods of contraception or underwent sterilisation in the previous year. For the age group 36-45 years, 46.3 per cent had previously undergone sterilisation. In contrast, not a single cohabiting man between 18 and 35 years had undergone sterilisation. (Table 7.1)

The distribution across rural and urban sample indicates that 76 per cent of the pregnancies, 75 per cent of the deliveries, 56 per cent of the abortions and 71 per cent of the contraception use occur among rural women (Table 7.2). Underreporting of abortions (spontaneous and induced) is to be expected in a study of this nature. That more such events may have been missed in the rural households is also very likely. Another problem faced was that information was incomplete, in many instances, as women tend to go to their natal or in law's homes for childbirth. A large number of deliveries occur in the woman's mother's home though most of the pregnant women resided with their in-laws or in their own home.

Pregnancy

There were 105 pregnancy recorded in the study, women who were pregnant at the time of the interview. Ante-natal care was not given to women till the fifth month of pregnancy and it was customary for them to start receiving prophylactic supplements and immunisation only in the last trimester. Thus, 34.9 per cent of the pregnant women in our study had not used any health facilities. In rural areas, the

largest number of women used public health care while in urban areas, private health care was more frequently used. (Table 7.3)

As part of the state health programme, providing ante-natal care to women is an important aspect of the work of the Auxiliary Midwife Nurse (ANM) posted at the sub-centre in each village. Only four women in rural areas and none in urban areas were visited at home by government health workers. The majority of the women themselves travelled to the health centre. Rural women were more likely to travel to receive care during pregnancy though only seven women had to travel for a distance of more than an hour.

Expectedly, medical care received by women during pregnancy included examinations, prophylactic treatment and immunisation. Testing of blood and urine was done only in five pregnancies. Use of sonography was not recorded at all.

Delivery

Use of health care during delivery (including combined use for delivery and contraception, delivery and post natal care) was common. However, there was great variation in the type of providers used (Table 7.4). In rural areas, 70.3 per cent of the deliveries were conducted at home by relatives or untrained practitioners. Also, 21 of the 61 births in urban area were attended at home by untrained persons which was surprising.

In contrast to pregnancy, use of public health services for delivery was very high — 42.6 per cent of urban childbirths were conducted in public centres. This shows the peculiar development of maternal and child health services in India. While in rural areas pregnant women were covered extensively by government health personnel, these services were absent at the critical time of childbirth. In contrast, in urban areas where emergency transport was easily available and health centres were physically accessible, nearly half the women chose to deliver in a public centre. Thus, **the use of government services depends greatly on the woman's *own* ability to reach the health centre in time.**

Although, most deliveries in rural households recorded in our study were normal births, very few were conducted by the ANM at home as would be ideally expected. Only nine deliveries were conducted at home by trained personnel as against 117 by untrained persons. This indicates the failure of the outreach programme to serve women at the most critical period of the maternity event.

Expectedly, there was a wide range of procedures and treatments involved (Table 7.5). Four caesarean sections were performed in urban area, while seven births involved episiotomy. Stitches were made in five cases. Though only one instance of blood transfusion during delivery was reported, 19 women were administered saline. Immediately, after delivery, four women also underwent tubectomy. In a substantial 26 deliveries, an injection was administered to induce labour. However, it must be noted that the services provided during non-institutional deliveries were more standardised. It included massaging the stomach, cutting the cord with a blade and bathing the baby. There was no mention of complications or specialised procedures such as rotating foetus.

The median duration of stay for institutional deliveries was three days. However, the range of the duration of stay extended from a day to 40 days. (Table 7.6). **Women in rural areas, where the births were largely conducted at home rested for a shorter period of time.** The mean duration was 32 days, (median 30 days). In urban areas, we find that the mean period of rest was 39 days (median 45 days). The number of days of rest permitted to the woman after delivery varied with **the context in which the child was born. For the first child, women rested for the 39 days, as compared to 27 days for the 4th or later child.** The composition of the household also played a significant role in determining the period of rest. For women who had no other grown woman (above 12 years) in the house, the period of rest was a short 29 days compared to 38 days for women in households having three or more women. Not surprisingly, women delivering in their mother's home

rested the longest but it is worth noting that those residing with in-laws rested longer than those who lived alone. This indicates the crucial contribution of other women to the opportunities available to women for preserving her health.

Post Natal Care

Barely 38.4 per cent of deliveries – 94 of 245 — were followed by post- natal care. While there was after care for 34.4 per cent of the deliveries in the rural areas, more than half the deliveries were followed by postnatal care (56.5 per cent) in urban areas. As expected, a large proportion of the health facilities used for such care were public centres — 60.9 per cent in rural and 52.6 per cent in urban areas. In rural areas, a home visit by a trained person (invariably a government paramedic) accounted for another 15.63 per cent of the health facilities, thus indicating that the public sector is used very widely for accessing postnatal care (Table 7.7)

However, this was limited to immunising the child. In some cases, a T.T injection was given following a home delivery. Curative services were sought from both private and public centres as also from health personnel visiting the women at home. Institutionally, the hospital, nursing home and PHC accounted for 19 facilities, with outreach workers accounting for 11, and the sub centre clinic accounting for 9 facilities. This indicates again that the secondary and tertiary care centres were utilised for postnatal care. Where only immunisation was provided, the sub-centre, outreach workers and schools were the most frequently used centres (29 facilities). It is a common observation that immunisation services are provided through camps or periodically in sub-centre where facilities for providing treatment for post-natal women are very inadequate.

Abortion and after care

A range of facilities was used for abortion after care services. (Table 7.8) More private facilities were used in urban area while informal providers were sought in rural areas. This provider in a majority of the cases, (6 in rural and 7 in urban) were 'doctors'. Though it is not certain whether these providers were fully qualified, they certainly practised within the modern system of medicine. In rural areas, a midwife and a herbalist were also involved.

The services received during and after abortion indicate that surgical procedures were performed in eight facilities. Administration of saline or blood transfusion was done in two facilities, while the rest of the services included dispensing and investigations.

Contraception

In the large majority of the cases (34 cases), contraception involved tubectomy. Only in six cases was IUD insertion reported while oral contraceptives were limited to eight cases. For contraception services, public facilities were used overwhelmingly. (Table 7.9) The average stay after tubectomy was six days in rural areas and four days in urban areas. The extensive use of public facilities for contraception is the obvious result of the great emphasis placed on family planning by state agencies. Also tubectomy, a permanent method is promoted more aggressively than the temporary methods. It must also be noted that **women regularly received monetary compensation after tubectomy. This was not the case in the use of IUDs or pills.**

Expenditure on events and contraception

Due to the small number of cases in each category, it was not possible to analyse expenditure on each type of event individually. Instead, events have been categorised into groups, antenatal/postnatal care, post abortion care, delivery and induced abortion, and contraception. (Table 7.10)

It showed an expenditure of rupees 319 per facility. Due to high no response rate for expenditure information, only cases with valid expenditure data have been included. There was a co-relation with many socio-economic factors: the highest expenditure

was incurred in easily accessible rural households, expenditure diminished with declining access, urban expenditure exceeded rural expenditure considerably. However, there was a vast gap in the expenditure incurred by slum and non-slum households in urban areas. While it was Rs. 212 in slum households, it was Rs. 203 for non-slum ones.

Similarly, there was a positive co-relation between class status and expenditure. The highest socio-economic class spent eight times more money per facility than the lowest socio-economic class. The other noteworthy co relation was with the earning status of women. More expenditure per facility was incurred on housewives than on employed women. Regarding the composition of the household, family size was inversely related to expenditure — larger the family size, lower was the expenditure per facility. However, the number of women in a household, which was crucial in determining utilisation, was not co-related to expenditure. Also, the order of birth of the child was highly co-related to expenditure — more care was taken for the first child and significantly less spent on a woman bearing the fourth or later child.

Desegregating the information on expenditure for each type of event, consistent trends were observed in relation to delivery and abortion. They accounted for the bulk of expenditure on events, also showed consistent patterns of expenditure.

Then, expenditure in urban areas for the same type of service was considerably higher (Table 7.11). This is in correspondence with the observation that use of private facilities is more common in the urban areas. The expenditure on complicated deliveries (requiring the presence of a doctor) was strikingly high. Expenditure on normal deliveries, which were largely conducted by midwives in rural areas and to some extent in urban areas, was considerably lower.

It is important to note that the surgery involved in these events was largely tubectomy conducted in public centres. Hence the expense incurred on these is not significant. In the case of 24 women, monetary compensation was received after sterilisation, and IUD insertion. This was in the range of Rs100 to 150. The use of a government vehicle was also provided in these instances.

Morbidity due to Events

Maternity and contraception-related morbidity is an important component of morbidity for this study because women tend to associate many of their health problems to these events. However, women receive inadequate care and rest during their childbearing phase. The low quality of care during tubectomy as well as a complete absence of follow up care is also well known. Hence, it is important to consider again the possibility of there being an association between these events and women's ill health.

Regarding complications and health problems during the event (Table 7.12), women reported a wide range of complaints. A large proportion of these complaints related to aches and pain. Significantly, back and stomach pain during pregnancy and stomach pain after delivery was frequently reported.

To understand the long-term morbidity resulting from childbearing and contraception, a separate analysis of morbidity information for women who had a pregnancy, delivery, abortion or contraception use in the past year was attempted. The morbidity information as noted earlier was collected for a month prior to the interview.

Information for women in age group of 18 to 45 years who had had an event in the previous year was compared with those who did not (Table 7.13). 346 episodes of illness were recorded for women in the former category and there were certain differences in the pattern of morbidity with other women. Reproductive illness, aches and pains were more significant for the former group. About 15.6 per cent of the episodes for women in this age group occur among those had an event in the reference period; their share of reproductive illness, aches and pains and weakness is more than 15 per cent. This indicates that **certain categories of health problems do become more frequent after a maternity event.**

An analysis of specific symptoms reported by women who had an event in the reference period (Table 7.14), showed that 26.8 per cent of the symptoms related directly to a reproductive illness while 31.5 per cent were aches/pains unrelated to reproductive health. It is important to note that general body pain is the most commonly reported symptom by this group of women. **In general, the symptoms suggested the presence of weakness and general debility coupled with reproductive problems and acute infections.** Given the fact that women received inadequate care during childbearing and resumed work soon after, these can be seen as the result of neglect and inadequate rest. It is not difficult to understand how **the repetition of this cycle of childbearing and illness can result in long standing health problems which women relate to maternity and contraception.**

Not surprisingly, the illnesses of women who had an event in the reference period were not treated in 50 per cent of the cases. The type of facilities used by all women in this age group was similar. Public providers were used marginally more frequently by women who had an event, may be because of their greater contact with these facilities during antenatal or postnatal care (Table 7.15). However, health problems were not specifically probed into nor were curative services routinely provided to women availing maternal and child-care in public facilities. However, the fact that 50 per cent of the complaints of such women remain untreated indicates the dire need for such services. As noted above, the percentage of women receiving antenatal and postnatal care was very low. They are denied even the standard prophylactic supplements and immunisation provided through the MCH programme. It is worth considering whether the inclusion of curative services in this programme would increase the use of these services and thus make childbearing and contraception use safer for women.

Conclusion

The data on maternity events and contraception use was too limited for an in-depth analysis. Still it is possible to draw some conclusions.

The use of antenatal and postnatal care is not universal. Prophylactic treatment and immunisation is taken, if at all, only in the third trimester.

The use of postnatal care is only incidental, related largely to the need to immunize the infant.

The use of public health services for such care is substantial, which indicates that state services have a major role to play in providing maternal and child-care. In their absence, it is likely that the use of health care during motherhood may decrease even further.

Public services are used extensively for contraception services too, particularly true for sterilisation. Given the state's emphasis on family planning, this is not surprising. As the state not only provides free services and transport facilities, but also monetary incentives, it is natural that public services will be preferred. Thus, the role of the state services in providing safe contraceptive services cannot be more emphasised.

The focus on family planning does not lead to more concern for the safety and health of women as reflected in poor coverage of women during pregnancy and postnatal phase. The need is to integrate these services with general health services to enable women get access to more health care in these crucial periods.

Reasons for neglect of women's health during this period have deep social roots. While rest and care is the right of every woman in this period, these are rarely provided. The lack of health care services only adds to the neglect. Considering the condition in which women bear children and also prevent their birth, it is not surprising to find **that they view many of their health problems as being the result of the hard reproductive labour that they undertook.**

Table 7.1 Number of events reported in the reference period by women of different age groups

Event	Age group in years							
	12 - 17	18 - 25	26 - 35	36 - 45	46 - 55	> 55	No resp.	Total
Pregnancy	10	69	19	6			1	**105**
Abortion								
Induced	1	7	3	1				12
Spontaneous	1							1
Unspecified	1	1	1					3
Total	**3**	**8**	**4**	**1**				**16**
Delivery	11	157	66	8			3	**245**
Contraception								
(Male)								
In the ref. Year			8	4	1	1		14
Sterilised previously				7	18	13	3	41
Total			8	11	19	14	3	**55**
Contraception								
(Female)								
In the ref. Year	2	33	24	2	1			62
Sterilised previously		59	214	133	57	18	14	495
Total	**2**	**92**	**238**	**135**	**58**	**18**	**14**	**557**

Table 7.2 Number of events reported by women in the ref. Period by rural and urban women

Event	Rural	Urban	Total
Pregnancy in the ref. year	80	25	105
Delivery in the ref. Year	184	61	245
Abortion in the ref. Year			
Induced	6	6	12
Spontaneous	1		1
Unspecified	2	1	3
Contraception in the ref. Year	44	18	62

Table 7.3 Type of facility utilised by women in pregnancy in the ref. Period

Type of health facility	Rural		Urban		Total	
Not Used	29	35.4	9	33.3	38	34.9
Self care	3	3.6			3	2.7
Public	29	35.4	6	22.2	35	32.1
Private	12	25.6	7	29.6	20	18.3
No Response	9	11.0	4	14.8	13	11.9
Total	82	100.0	27	100.0	109	100.0
Location where care received						
At public centre	24	29.3	6	22.2	30	27.5
At private centre	12	14.6	7	25.9	19	17.4
Untrained at home	1	1.2			1	0.9
Home visit by trained per'nl	5	6.1			5	4.6
Any other	2	2.4	1	3.7	3	2.8
Not used	29	35.4	9	33.3	38	34.9
No response	9	11.0	4	14.8	13	11.9
Total	82	100.0	27	100.0	109	100.0
Physical location of health facility						
At home	4	4.9			4	3.7
Own village	22	26.8	14	51.9	36	33.0
Non PHC village	2	2.4			2	1.8
PHC village	2	2.4			2	1.8
Large village	8	9.8			8	7.3
Taluka town	6	7.3			6	5.5
Bombay	1	1.2			1	0.9
Not applicable	29	35.4	9	33.3	38	34.9
No response	8	9.8	4	14.8	12	11.0
Total	82	100.0	27	100.0	109	100.0
Distance to health facility						
No distance	37	45.1	11	40.7	48	44.0
Less than an hour	16	19.5	7	25.9	23	21.1
Half to one hour	6	7.3	3	11.1	9	8.3
One to three hours	6	7.3			6	5.5
More than three hours	1	1.2			1	0.9
No response	16	19.5	6	22.2	22	20.2
Total	82	100.0	27	100.0	109	100.0

Note: Number exceeds total number of events due to multiple utilisation

Type of treatment received						
Gave Advice/ Exam/ Pres.	14	19.2	6	26.1	20	20.8
Gave Medicine/ Tonics/ Inj.	28	38.4	6	26.1	34	35.4
Blood Test / Urine Test	2	2.7	1	4.3	3	3.1
Saline	1	1.4			1	1.0
Gave T.T. Injection	23	31.5	10	43.5	33	34.4
Rituals	1	1.4			1	1.0
Herbal Medicine	2	2.7			2	2.1
Routine Ante Natal Care	2	2.7			2	2.1
Total	73	100.0	23	100.0	96	100.0

Note: No response in 13 cases.

Table 7.4 Type of facility where care provided during delivery

Location where care given	Rural		Urban		Total	
At public centre	24	14.6	26	42.6	50	22.2
at private centre	14	8.5	11	18.0	25	11.1
Untrained midwife at home	103	62.8	16	26.2	119	52.9
Relatives	14	8.5	5	8.2	19	8.4
Home visit by trained govt. personnel	9	5.5	1	1.6	10	4.4
Any other			2	3.3	2	.9
Total	**164**	**100**	**61**	**100**	**225**	**100**

Note: No response, Rural = 20

Table 7.5 Type of Provider and Treatment Received During Delivery In The Formal And Informal Sector

Type Of Provider And Treatment Received	Rural	Urban	Total
Formal Sector Provider			
Examined	4		4
Gave Prescription	1		1
Gave Medicine	4	10	14
Saline	11	8	19
Transfused Blood	1		1
Gave T.T. Injection	3	4	7
Gave Injection To Induce Labour	11	6	17
Aneasthetic		2	2
Conducted Natural Delivery	43	29	72
Episiotomy And Delivery	3	4	7

Ceaserian Delivery		4	4
Tubectomy	2	2	4
Gave Injection	6	3	9
Took Stiches	3	2	5
Cut Cord With Blade		3	3
Bathed Baby		1	1
Dressing		1	1
Informal Provider			
Any Other	1		1
Massaged Stomach	9	4	13
Gave T.T. Injection	1		1
Conducted Natural Delivery	114	23	137
Cut Cord With Blade	13	17	40
Bathed Baby	3	6	9

Table 7.6 Numbers of days of rest after delivery according to characteristic of women

		No of days of rest	Number of deliveries
Total		**34**	**206**
Order of birth of child	First child	39	61
	2-3 child	35	95
	4 or later child	27	50
Area	Rural	32	151
	Urban	39	55
Rural	Easy access	35	75
	Difficult access	30	54
	Remote	28	22
Urban		39	55
Number of women in h'hold	One woman	29	71
	2 women	35	62
	3 or more women	38	73
Residence	Own home	27	25
	Mother's home	39	87
	In law's home	34	69
	Any other	37	1
	No response	25	24

Note: No response for days of rest in 39 cases

Table 7.7 Type of health facility utilised for post-natal care

	Rural		Urban		Total	
Health Facility Utilised						
At Public Centre	39	60.9	20	52.6	59	57.8
At Private Centre	9	14.1	11	29.0	20	19.6
Untrained At Home						
Self Care	1	1.6			1	1.0
Home Visit By Trained Personnel	10	15.6	3	7.9	13	12.8
Self Medication						
Any Other	1	1.6	4	10.5	5	4.9
	64	100.0	38	100.0	102	100.0

Note: Facilities exceed events because of multiple utilisation

Table 7.8 Type of facility in which abortion care provided

	Rural	Urban	Total
Location where care provided			
At public centre	3	2	5
at private centre	2	6	8
Untrained at home	1		1
Self care		1	1
Home visit by trained person	1		1
Any other	1		1
Not used	2	1	3
No response	1	1	2
Total	**11**	**11**	**22**
Type of treatment			
Exam & Dispensing	2	3	5
Investigation		2	2
Surgery	4	4	8
I.V saline, blood transfusion	2		
Not treated	2	1	3
No response	1	1	2
Total	**11**	**11**	**22**

Note : Number exceeds number of abortions due to multiple utilisation

Table 7.9 Contraceptive care

	Rural	Urban	Total
Type of facility			
At Public Centre	27	9	36
At Private Centre	2	3	5
Home Visit By Trained Personnel	2		2
Self Medication		3	3
Not Used		1	1
No Response	4		4
Total	**35**	**16**	**51**
Type of treatment			
Exam & Dispensing	4	4	8
Minor OPD procedure	1	5	6
Surgery	27	7	34
No response	3		3
Total	**35**	**16**	**51**

Note: Other contraceptive use is combined with delivery and abortion

Table 7.10 Expenditure on events and contraception

	ANC/ PNC/ Pst. Ab Care	Delivery Or Abortion	Contraception	Combined Mean Exp.	Facilities
Area					
Rural	45 (127)	473 (140)	131 (25)	257	292
Urban	129 (60)	807 (64)	183 (14)	449	138
Access					
Easy Access	91(55)	669(73)	176 (16)	394	144
Difficult Access	10 (58)	276(46)	39 (8)	121	112
Remote	5(14)	222(21)	150(1)	136	36
Urban Slum	71(45)	331(54)	203(6)	212	105
Urban non slum	302 (15)	3381(10)	168(8)	1203	33
Socio Economic Class					
Non worker, unskilled	63 (39)	237 (51)	147 (6)	161	96
Formal sector/unskilled	24 (51)	334 (55)	75 (8)	177	114
Formal sector skilled	18 (68)	359 (67)	261 (15)	195	150
Professionals, trade	304 (28)	2089 (30)	45 (10)	1054	68
Order of Child					
First Child	76 (80)	825 (66)	14 (7)	396	153

2-3 Child	97 (74)	562 (87)	136 (17)	328	178
4 or later child	6 (32)	277 (50)	228 (15)	180	97
Size of the family					
1-5 members	59(65)	769(64)	164(10)	393	139
6-10 members	55 (92)	534(108)	167(23)	299	223
11-15 members	185(24)	330(29)	86(4)	252	57
More than 15 members	10 (5)	383(2)	0(2)	91	9
Earning status				319	428
Non earners	1553 (2)	1088 (3)		1274	5
House workers	113 (73)	782 (92)	225 (16)	463	181
Earners	19 (111)	389 (108)	97 (23)	191	242
Type of facility					
Institutional	86(124)	1119(80)	176(33)	447	237
Non institutional	127(19)	236(120)	5(5)	213	144
No treatment	0(40)	0(3)	0(1)	0	44
No response	95(4)	50(1)		86	5

Note: Figures in parenthesis are number of facilities.

Table 7.11 Expenditure according to type of treatment

Type Of Treatment	Rural		Urban		Total	
	Mean Cost	Facilities	Mean Cost	Facilities	Mean Cost	Facilities
Exam & Dispensing	57	93	81	50	65	143
Investigation	100	1	232	3	199	4
Minor OPD Procedure	0	1	456	7	399	8
Surgery	170	22	389	9	233	31
I.V, Saline, Blood Trans.	100	3			100	3
Normal Delivery	280	121	438	44	322	165
Complicated Delivery	1990	16	2229	14	2102	30
Not Treated	0	32	0	10	0	42
No Response	0	3	55	1	14	4
All Facilities	**257**	**292**	**449**	**138**	**319**	**430**

Table 7.12 Type of Problem reported with event

Type of problem	Preg.	Delivery	Abortion	Contra.	Total
General					**105**
Vomiting	13	2	1		16
Stomach-ache	10	34	3	1	48
Backache	10	4	1		15
Any other problem	4	7	1	1	13
Fever		8	1		9
Cough	1	1	1		3
Headache		1			1
Weakness					**17**
Weakness	1	3		2	6
Dizzy spells	2				2
Pain of limbs	4				4
Feet swell	1	2			3
Less blood		2			2
Gynaecological					**14**
Burning urination	2	1			3
White discharge				1	1
Bleeding		4	5	1	10
Obstetric					**37**
Stiches infected		1		3	4
Breast tender, congested		1			1
Patches on breast		1			1
Delayed periods		1			1
Painful labour	1	23	2		26
Premature delivery	1	3			4
Total	**50**	**99**	**15**	**9**	**173**

Table 7.13 Type of morbidity reported by women with or without event

Type of morbidity	No event in the ref. period			Event in the ref. Period		
	Episodes	Column %	Row %	Episodes	Column %	Row %
Reproductive	403	21.6	78.7	109	31.5	21.3
GIT	121	6.5	85.8	20	5.8	14.2
Weakness	132	7.1	79.5	34	9.8	20.5
Aches/pain	270	14.5	78.9	72	20.8	21.1
Fevers	380	20.4	91.3	36	10.4	8.7
Respiratory	252	13.5	91.3	24	6.9	8.7
Sense organs	178	9.5	84.4	33	9.5	15.6
Inj./boil/burn	29	1.6	82.9	6	1.7	17.1
Mental stress	34	1.8	91.9	3	0.9	8.1
Others	66	3.5	88.0	9	2.6	12.0
Total	1865	100	84.4	346	100	15.6

Table 7.14 Specific symptoms reported by women reporting event

Complaint	Responses	%Total Responses	Sub total (%)
Reproductive backache	59	11.9	**Reproductive problems**
R.T.I	26	5.3	
Reproductive abdominal pain	23	4.6	
Uterine prolapse	9	1.8	
Pain during intercourse	7	1.4	
Menstrual problems	5	1.0	
Painful menstruation	3	.6	
Burning urination	1	.2	**133 (26.8)**
Aches and pains	87	17.6	**Aches and pains**
Non reproductive backache	35	7.1	
Head ache	20	4.0	
Stomach ache	14	2.8	**156 (31.5)**
Fevers	47	9.5	**Fevers, respiratory and acute problems**
Cough, pneumonia	20	4.0	
Diarrhoea, vomiting	18	3.6	
Sore throat and Cold	13	2.6	
Other acute problems	6	1.2	**104 (20.9)**
Weakness, dizziness	44	8.9	**Weakness related pr.**
Night-blindness	5	1.0	
Breathlessness	4	.8	**53 (10.7)**

Problems of eyes and ears	23	4.6	**Sense organ problems**
Boils, skin probs, hair	11	2.2	
Injury, burns , bites	6	1.2	
Oral health problems	1	.2	**41 (8.2)**
Mental stress			**3 (.6)**
Other chronic problems			**5 (1.0)**
Total responses	**495**	**100**	

Table 7.15 Type of facilities used by women between the age of 18 and 45 years.

Type of facility	**No event in the Reference Period**		**Event in the Reference Period**	
Self care	140	11.9	18	9.8
Chemist	121	10.3	19	10.3
Traditional Practitioners	59	5.0	12	6.5
Care by unqualified practitioners	8	0.7	1	0.5
Informal care	***328***	***27.9***	***50***	***27.1***
Care by private Doctor	619	52.5	86	46.7
Care by government Doctor	113	9.6	30	16.3
Care by govt. paramedic	112	9.5	17	9.2
NGO, Company, any other	7	0.6	1	0.5
Formal Care	***851***	***72.2***	***134***	***72.9***
Total	**1179**		**184**	

8. Summary and Conclusions

Women's health is determined by many factors that are directly and indirectly related to health care. Apart from health services and medical knowledge, the social environment in which women work and live is an important factor in determining their health status. Thus, illness as perceived by women, is not merely as a biological phenomenon but a social process. Illness and health care is not a discreet aspect of their lives but interwoven into the experience of daily living.

The objective of this study was to determine differences in morbidity, utilisation of health care services and expenditure on health care based on differences in the social position of women. Also, to examine the differences in these variables in the context of age, marital status, caste, class and the position in the household.

The study covered 1193 households in rural areas of Igatpuri taluka (817 households) and the city of Nashik (366 households). These households were drawn from 13 villages and five urban clusters. There were 7212 individuals in these households, of whom 3631 were men and 3581 women. An interview was administered to each household, which elicited information on the profile of the individuals and the household, the illness suffered by any member of the household in the past month and the health care utilisation and expenditure incurred. Information was collected on all maternity events — pregnancy, delivery, abortion — during the past year; as also on contraception use in the same period. Any one woman of the household above the age of 12 years was selected as the respondent.

An attempt was made to make the methodology of the study sensitive to women's experience through designing tools, using women investigators and using a probe list of symptoms to record additional illnesses among women above 12 years. The interviews were conducted in an environment that made it possible for women to speak openly about their health problems without preconceived categories and boundaries.

Key Findings

1. The quantum of morbidity among women was higher than that reported in earlier household surveys. In fact, morbidity reported among men was also higher than in any previous survey. The difference in the morbidity recorded prior to probing between males and females was not substantial – it was 330 per 1000 for men and 362 per 1000 for women.

2. Probing increased the morbidity rate for women — 812 per 1000. 307 men out of every 1000 reported an illness in the reference period. Prior to probing, 339 out of every 1000 women had reported an illness but probing resulted in the number rising to 516.

3. Illness among men was dominated by infectious morbidity of short duration. Most episodes of illnesses had duration of less than 3 weeks. However, among women, a large number of illnesses were of a chronic and non-infectious nature.

4. **The pattern of morbidity among women showed linkages to their living environment (air, water, food), work and childbearing and contraception.** Morbidity among adult women was higher than the morbidity among girls, and had a substantially large proportion of chronic and non-infectious illness.

4(a) Reproductive health problems were more prevalent among young women while weakness, aches/pains constituted a large part of the morbidity of ageing women.

4(b) Morbidity was highly co-related to age, marital and occupational status. Apart from these, the socio-economic class and the composition of the household also co-related to morbidity.

4(c) Cultural factors inhibit reporting of morbidity,

as was seen in the case of tribal women who reported lower morbidity than women living in another social environment. Also there were distinct influences of age and social status on reporting morbidity. As women age, get married, or become single again, their own understanding of their health problems changes. This is reflected in the changing pattern of morbidity seen in these groups of women.

5. Utilisation of health care by women was low relative to the quantum of morbidity reported by them. 45 percent of the episodes were not treated.

5(a) Use of informal care was an important part of women's health seeking behaviour. While home remedies constituted 15 per cent of the services, self medication accounted for 11 per cent of the total services used.

5(b) Use of informal care of this type was higher among urban than rural women. This finding is complemented by the fact that the non-treatment of illnesses among women was also higher in the urban areas.

5(c) Extensive use of informal services was found combined with an overall low use of health care. In urban areas, women sought treatment for 49 per cent of the episodes reported by them and used 21 informal facilities for every 100 episodes. In contrast, rural women sought treatment for 57 per cent of the episodes and used 15 informal facilities for every 100 episodes. The use of informal care was also determined by the nature of illness. In general, chronic and non infectious illnesses were more likely to treated with informal care.

5(d) The most striking co-relation of health care use was found with the position of women in their households. 'Dependant' women - unmarried girls and aged women used more health care per episode than women who were heads of the household or wives of male heads.

5(e) Use of formal services by urban Muslim women is extremely low while the use of informal care is very high. In general, women from deprived groups - women from remote villages, scheduled castes and urban minority community women did not receive health care for a large proportion of their illnesses.

6. **There was a marked difference in the use of formal public facilities in rural and urban areas.** In rural areas, 24.2 per cent of all facilities used and 30.3 per cent of the formal facilities used by rural women were government facilities or home based care provided by government paramedics. In urban areas, 10 per cent of the total facilities and 17.3 per cent of formal facilities used were public sector services.

6(a) The rate of hospitalisation was significantly higher among rural women — in-patient care was received in 1.1 per cent of the episodes reported by rural women and in only 0.5 percent of the episodes reported by urban women. The concentration of health facilities (especially those providing secondary and tertiary level care) in semi-urban and urban areas compels rural women to travel long distances and seek in-patient care more frequently.

7. Certain types of illnesses, such as aches/pains, injuries, weakness and sense organ problems were mostly treated in the informal sector. However, other illnesses such as fevers and gastro-intestinal infections were almost invariably treated using formal health care.

8. Health care utilisation is related to the nature of illness. This was borne out by the finding that long-term illness was not treated as frequently as short-term (largely) infectious illnesses — only one-fourth of the illnesses with a duration of four weeks or less were not treated while more than half of the illnesses persisting for a longer period were not treated.

9. The perceived efficacy of treatment was an important factor in determining the use of health care. Women reported that the treatment they

sought for fevers, gastro-intestinal infections and injuries, boils and burns was highly effective, whereas treatment for other types of illness was not so. An interesting co-relation was found between perceived efficacy of treatment and the duration of illness — while treatment sought for short term (largely) infectious illnesses was highly effective in completely curing the person, illnesses of one month to one year duration were less amenable to complete cure. However, as the illness becomes more long term, women adhered to a mode of treatment that though did not effect a complete cure gave partial relief.

An analysis of the reasons for not seeking treatment, showed that in 40 per cent of the cases, financial problems were the cause. In 23.2 per cent of the cases, women felt that the nature of the illness did not require treatment. Treatment was not sought for 12.4 per cent of the episodes because health facilities were not accessible or adequate.

10. **The expenditure on health care showed trends corresponding to the utilisation of health care.** Expenditure per episode, per capita and per facility in the rural areas was higher than in urban areas. In the overall pattern, the cost of in-patient care as well as out-patient care in rural area is lower. However, due to more frequent hospitalisation among rural households, the overall rural expenditure on health care shows a considerable rise.

10(a) Among women, expenditure on both types of facilities in urban areas was lower. This may be due to the extensive use of informal care but this finding remains difficult to explain.

10(b) Among the components of expenditure, doctors' fees, the cost of medicines and injections comprised the major part of out-patient expenditure. The cost of surgery and hospitalisation, though infrequent, was extremely high. Thus, rural households had to incur higher expenditure for health care due to more frequent hospitalisation.

10(c) Expenditure incurred on different types of illnesses revealed that gastro-intestinal and respiratory illnesses had a high per facility cost primarily because they were treated using formal services. However, though the per-facility cost of treatment for fevers was low, the expenditure was high as a proportion of total expenditure.

10(d) Expenditure was highly co-related with the duration of illness. The longer the duration of the episode, the lower was the per episode expenditure on it. This is due to the fact that the rate of treatment and the use of formal care for long-term episodes was both low.

10(e) The type of treatment also influenced the expenditure on health care. When medicines alone were dispensed, the per-facility expenditure is Rs. 24. However, when injections were also administered, it rose to Rs 77. This indicates the economics behind the overuse of injections in the private sector.

10(f) **There was considerable difference in the expenditure incurred on men and women in each facility.** The cost of inpatient (hospitalised) care was considerably higher than the cost of outpatient (non-hospitalised) care. The expenditure per facility differs due to the use of more or less formal care and the higher or lower rates of treatment.

Also women who bear more responsibility in the households spent less on health care; while young girls' illnesses were treated often, the expenditure incurred on adult women was not that high. Similarly, the expenditure incurred by women of deprived groups, scheduled castes and tribes was very low.

11. The findings on maternity events and contraception **revealed the low access to health care for rural women during maternity.** 29 of the 82 pregnant women had not sought any antenatal care. Also 70 per cent of the deliveries in rural areas were conducted by relatives or untrained midwives.

11(a) However, we find that in the urban areas too, one third of the deliveries were conducted at home by similar providers. The number of days that a woman rested after delivery also varied in the rural and urban areas, the former resuming work earlier than the latter. Also women rested more if they were delivering their first child or if they were in their natal home.

11(b) Only 38 per cent of the deliveries were followed by postnatal care, the percentage was higher in urban than in rural areas. Primarily, public centres were used for postnatal care because immunisation facilities are provided at the centres and women accessed them to have the baby immunised. Travelling to the health centre, specifically for postnatal care, was very rare.

12. **Contraception services were overwhelmingly accessed from the public sector, except the use of medicine shops to buy oral contraceptive pills.** In fact, services used during sterilisation were in sharp contrast to delivery services available to rural women. **While women were left to depend on their own resources for delivery and maternal care, all services including the use of a vehicle were made available for tubectomy.** This indicates clearly the priorities of the health service, which shows considerable efficiency and resourcefulness when required. As tubectomy is a planned event, it is much easier to make personnel and resources available on time but the fact remains that emergency care which should be readily available to women, is not even thought of. The unanimous reply to the question, "what do you do when a woman is having difficulty during childbirth" was that villagers themselves would carry her or transport her by vehicle to the nearest health centre.

Key issues

IT IS NECESSARY TO REITERATE that the main objective of the study was to capture not merely the totality of women's health problems and needs but also to trace the intricate links between various factors. It is important to raise questions about the methodology widely adopted to study household health care — the survey. The study rendered problematic certain concepts widely used in these studies - such as episode and health care facility.

The manner in which illness was recorded and coded can radically alter the picture of morbidity reflected in a study. Similarly, by recording behaviour rather than merely health facility use, a vast area of informal health care providers is revealed. This study also confirms the possibility of reducing the social barriers in reporting of morbidity by using sensitive tools and field methodology. This is an important point if such studies are to be useful in any debate on development.

While the quantum of illness reported is an important indicator, the varied pattern of morbidity helps to reveal the complexity of women's health problems. The clear **co-relation between probing and the type of illness reveals this. Women tend not to report problems related to work and fatigue, childbearing and contraception. They also seldom seek treatment for it. Thus, a large proportion of their illness is obscured from view because it does not enter the health system at all.** Much of this untreated morbidity has its roots in the social structures that women live in. Their sex decrees the existence of a certain set of roles and responsibilities that make it difficult for them to look after themselves. Of course, poverty puts enormous constraints on the entire family but women in general and poor women in particular lack adequate food, rest and care.

However, it would be wrong to imagine that women are passive victims. Women's oppression stems not so much from their powerlessness, as much as from their perception of their duties and responsibilities. Hence, **those who enjoy the most (of the limited) autonomy afforded to women within the structure of the family are, in fact, reporting the highest morbidity and the least use of household resources for health care.**

What can be done to improve women's health?

The discourse of development has outlined some strategies, education, employment, more accessible health care services. These remain as relevant today as ever. However, it is imperative to remember that the household remains one of the most important agencies in determining women's health opportunities. While women bear the responsibility for the survival of the household, they experience very little freedom in making choices in their own lives.

The re-distribution of power within the family can radically alter the decision making process in the household. Attempts to improve women's health, therefore, must take a broad view of health care. It is necessary to influence household processes in a way that makes women more able to make their own choices.

At the same time, it is important to remember the context in which the households exist. **Pervasive poverty and unemployment, which makes households vulnerable, have a deep effect on women who bear the responsibility of the survival of the household, often, at the cost of their own health and lives.** While the alleviation of poverty and empowerment of women are important, it is also worthwhile examining the role of the health services in this regard. **It is also evident from the study that health services are both inadequate and unequally distributed.** Lack of physical access to healthcare facilities in rural areas is an important pointer; it also increases expenditure. However, the use of public facilities is extremely limited even where the services are physically accessible both in the rural and urban areas. Therefore, it is important to re-examine the entire gamut of reasons for non-utilisation of these services.

Reforming the public health system

Our experiences show various problems in the provision of the public health services: hierarchical structure of the services and the high dependence of directives from above where village-level workers had no autonomy to decide the priorities and programmes for the village, though many villages had a full-time trained health worker (mostly, the ANM), health care needs of people remained unfulfilled as most of the workers spoken to were dissatisfied with the service and their role in it, health workers complained of paucity of equipment, drugs and, most importantly, referral backup, also that people had no trust in them as they were not able to provide curative services when needed, they found it difficult to even carry out health education and awareness programmes.

Also, permanent posts of medical officers had not been filled and many doctors were serving more than one PHC on a temporary basis. Their visits to the sub centre villages were infrequent and cursory. Remote villages were not visited at all by the PHC staff. Apart from the problems related to outreach, it was also found that the facilities, even where they existed, were insufficiently stocked. **This resulted in people losing faith in the public health system, as services were not satisfactory even when people themselves approached the primary health centres.** The facilities were not equipped to deal with emergencies and patients routinely had to be referred to urban hospitals.

The problems of the public sector services can only be partially remedied by stricter implementation of guidelines and re-organisation. Government funding for health also needs to be increased in order to meet the needs of rural and urban areas.

Role of the private sector

The major source of curative services in urban as well as rural areas is the private sector. However, as pointed out earlier, there was a vast variation in the types of private providers. They ranged from quacks, who rode into the village on motorcycles once a week and dispensed medicines to more than 40 patients in a couple of hours, to highly trained specialists in the urban centre of Nasik, who charged Rs. 200 to Rs. 500 for a single consultation. No record of the types

and number of private providers serving in a particular area could be found. **Apart from anecdotal information and direct observation, there was no evidence of their existence and manner of functioning.**

In sharp contrast to the public health sector, the private sector had no visible structure. There was clear evidence of demand driven development of these services. Remote villages were served almost solely by quacks, who visited once a week. There were fairly well-established dispensaries in some inaccessible villages, running prosperously because of the presence of rich farmers. They were also to be found in small villages, which had only a grocery shop and a flour mill, where they could attract patients from remote villages. This ability to spread services where they were demanded had enabled the private sector to make inroads into areas completely ignored by the public sector. However, **there is no record of the quality of care provided by these different providers.** There is a need to establish a system to ensure accountability and quality of care.

A study of the urban households reveals the importance of the market as a provider of health services. Poor households have extremely poor access to formal services and resort to the use of informal services. Utilisation of municipal services was extremely poor even among the residents of the slum settlements within the city. **The near-total dependence on private services clearly had a negative impact on poor women who were driven out by their inability to purchase services. It is evident that the withdrawal (or absence) of the public sector was resulting in greater neglect of poor women's health needs.** It is fallacious to believe that greater level of urbanisation and economic development will make it possible for households of all socio-economic classes to be served by the market. The need for equitable and accessible primary health care is as compelling in the urban as in rural areas. There is an undeniable need to strengthen the public services in the urban areas as well as to make them more accessible to the poor.

IN THE FINAL ANALYSIS, we find that there is a need to restructure institutions - whether it is the household or the health service. However, this structural change can hardly be engineered from above. Although studies like this can point out problems and, perhaps, show the direction in which to proceed, the greatest contribution that they could make is by initiating demand for change among those women whose problems were the starting point of this inquiry. This study therefore hopes to be a contribution to the struggle for women's empowerment, wherever it exists, in whatever form.

Sources and References

District Health Officer, Nashik District; Survey of Causes of Death, Rural; 1996; Nashik.

Duggal R. & Amin S.; Cost of health care; a household survey in an Indian district; 1989; F.R.C.H; Bombay

Executive Health Officer, Nashik District; Annual report of the Executive Health Officer; 1995; Nashik.

George A. et al; A study of household health expenditure in Madhya Pradesh; 1994; F.R.C.H; Bombay

Kannan K.P. et al; Health and development in rural Kerala ; 1991 ; K.S.S.P; Trivandrum

National Sample Survey; Morbidity and utilisation of medical services; N.S.S 42nd Round (1986-87); in Sarvekshana Issue no 52; Volume XV; no 4; April June 92; 1992; Govt. of India.

National Sample Survey; Morbidity and treatment of Ailments, NSS 52nd Round, July 1995-June 1996; Dept. of Statistics, Govt. of India; November 1998

NCAER ; Household survey of medical care ; 1992 ; NCEAR ; New Delhi

Sundar R.; Household Survey of health care utilisation and expenditure; working paper no. 53; 1995; NCAER; New Delhi

Annexure 1

Significant findings recorded in the earlier household health surveys

Name of the study	Recall period	Sample	Morbidity	Utilisation	Expenditure
F.R.C.H; Jalgaon; 1989	1 month. 3 rounds	543 households in Jalgaon tehsil	Morbidity rate Male: 145.27 Female: 152.99 Rural : 154.66 Urban: 141.85 Fevers - 32.6 percent of all episodes	9.17 percent of illnesses not treated 69.58 percent of epi. - injection use 77.09 facilities utilised - private sect	Per epi. Cost - Rs. 102.14 Rural per epi cost - Rs. 103.56 Urban per epi. Cost - 100.44 73.97 percent of expen. Fees and medicines
National Sample Survey; 42 nd round; 1986-87	1 month		Morbidity rate; Rural Male: 64 Rural Female: 63 Urban Male : 30 Urban: Female: 31	81.5 percent rural ailments treated 89.1 percent urban ailments treated 51.83 percent outpatient care (India) - private doctor 49.94 percent outpatient care, (Maharashtra) - private doctor 31.99 percent inpatient care (India) - private sector 53.38 percent inpatient care (Maharashtra) - private sector Major reason for not seeking treatment was that the illness is not considered serious (74.61 percent) and due to financial reasons (15.27 percent)	India Average total expenditure per treatment in the private sector in the rural areas - Rs. 84.93 Average total expenditure per treatment in the private sector in the urban areas - Rs. 91.30. Maharashtra Average total expenditure per treatment in the private sector in the rural areas - Rs. 86.59 Average total expenditure per treatment in the private sector in the urban areas - Rs. 136.55

K.S.S.P; Kerala; 1991	2 Weeks	9940 rural households	Morbidity rate Acute : 206.39 Chronic : 138.02 Disability - 1322 persons per one lakh 118.5 episodes of fever for every thousand persons (in a two-week period). Acute illnesses among women - 209.2 Chronic illness among females - 155.8 Chronic illness among males - 137.5	53 percent of the facilities utilised for acute illnesses in private sector. 12 percent of health services utilised were self-care.	Per capita cost of treatment - Rs. 16.56. The total per capita expenditure for the total population - Rs. 178.33 per year. 50 percent of the total health expenditure was spent on medicines, 18 percent of the total expenditure was spent on fees
NCAER; May-July 1990 survey recorded only treated illnesses	1 Month	371 districts of the country covering 18,102 households	Morbidity rate Rural 79.06 Urban - 67.70 urban areas Adult men - 88.07 Adult women - 46.62 Boys - 90.78 Girls - 40.49 Rural areas Adult women - 59.80 Adult men - 105.34 Boys - 93.95 Girls - 45.72 Fevers most prevalent illness in both rural and urban households, with 34.83 and 29.97 episodes recorded per thousand persons, respectively.		The cost of treatment per treated episode in urban areas - Rs. 142.60 The cost of treatment per treated episode in the rural areas. - Rs 151.81 Cost of care per episode in private sector in the urban areas - Rs. 164.44 Cost of care per episode in the government sector in the rural areas - Rs. 168.99. (inpatient and outpatient treatment costs are presented together)

F.R.C.H; Sagar and Morena districts of Madhya Pradesh; 1994	1 month In two rounds in the monsoon season of 1990 and a sub sample study in the winter months of 1991.	770 households and a total population of 5202 persons.	Morbidity Rate Total - 310.78 Rural Acute illnesses - 156.53 Chronic illnesses - 132.32 Urban Acute illnesses - 179.07 Chronic illness - 121.06 91.03 episodes of infections including fevers recorded for every thousand persons Morbidity was significantly higher for women after the age of 25 years and increased consistently with age.	69.05 percent of the facilities - private sector	Expenditure per capita per month - Rs. 24.93 Cost per episode of illness - Rs. 134.23. Expenditure per episode on doctors' fees and medicines -Rs. 99.12 Expenditure per month by every paying user - Rs. 149.04. Per episode expenditure in private facilities for males - Rs. 152.97 Per episode expenditure in private facilities for females - Rs. 143.39.

NCAER; May-June 1993	1 month	18,693 households spread over the rural and urban areas of the country.	Morbidity rate Rural areas-106.7 Urban areas-103.0 Female rural-108.1 Female urban-108.4 Aged population Males – 215 Females – 192 73 percent of the rural episodes - Acute illnesses Maharashtra Rural women-68.4 Urban women-79.5	46.3 percent of episodes - private practitioners 20.4 percent of the episodes. PHC/CHC based care Use of private facilities was more common in Maharashtra	India Per non-hospitalised episode expenditure in the rural areas – Rs. 90.48 Per non-hospitalised episode expenditure in the urban areas – Rs. 113.93. Maharashtra Per non-hospitalised episode expenditure in the rural areas - Rs. 90.71 Per non-hospitalised episode expenditure in the urban areas - Rs. 136.93 Per non-hospitalised episode expenditure in the rural areas in public facilities - Rs. 49.08 Per non-hospitalised episode expenditure in the rural areas in Private facilities - Rs. 130.06 Per non-hospitalised episode expenditure in the urban areas in public facilities - Rs. 62.90 Per non-hospitalised episode expenditure in the urban areas in Private facilities - Rs. 152.19 Self-medication was significantly less expensive than formal private care, the per episode expenditure being only Rs. 21.24.

NSS; 52nd round; 1995-96	15 day reference period		Monthly prevalence rate Rural - 86 Male - 84, Female – 89 Urban – 84 Male – 81, Female – 89 Tuberculosis most prevalent chronic illness - 83 per one lakh population in the rural areas 63 per one lakh in the urban areas.	83 percent of those reporting illness were given treatment in the rural areas the urban areas, the percentage of those receiving treatment was 91 percent. 52 percent of the cases in the rural areas, treatment was not sought because the illness was not serious. However, nearly one fourth (24 percent) of the persons reported that treatment could not be sought due to financial reasons. In the urban areas, the non-serious nature of illness accounted for 60 percent of the cases where treatment was not taken, while financial problems accounted for 21 percent of the cases. 81 percent of all sources of non-hospitalised health care - private sector only 11 percent of the total facilities used for non hospitalised care - Public hospitals 55 percent of the total facilities used for non hospitalised treatment - private doctors 438 of every thousand (43.8 percent) hospitalised treatment cases were recorded in the government institutions in the rural areas and 431 out of every thousand cases in the urban areas. Maharashtra, however, less than 32 percent of both rural & urban hospitalised cases were recorded in the public sector.	The average total expenditure per episode for non hospitalised cases in the rural areas-Rs. 144 The average total expenditure per episode for non hospitalised cases in the urban areas-Rs.175 The average total expenditure per episode for non hospitalised cases in the rural areas on females - Rs. 137 Total expenditure per episode for non hospitalised cases in the urban areas on females - Rs. 164 Per episode expenditure on hospitalised cases in public sector in rural areas - Rs. 2080 Per episode expenditure on hospitalised cases in public sector in urban areas - Rs. 2195 Per episode expenditure on hospitalised cases in private sector in rural areas - Rs. 4300 Per episode expenditure on hospitalised cases in private sector in urban areas - Rs. 5344 The expenditure on hospitalisation in public sector hospitals in Maharashtra was even lower than the All India average in both rural and urban areas.

Annexure 2

Centre For Enquiry into Health and Allied Themes
519, Prabhu Darshan, 31, S.S.Nagar, Amboli Andheri (W) 400 068
Phone: 6250363

HOUSEHOLD EXPENDITURE ON WOMEN'S HEALTH

Dear Sister,

We are conducting a study on women's health.

Our organisation has a special interest in health issues. It is a secular, non governmental organisation. It is five years old and is run by its staff. It is governed by Anusandhan Trust (Reg. No. E 13480). We have conducted many research studies in different parts of Maharashtra. People from different sectors and disciplines work in this organisation.

This study aims to understand those aspects of health which you understand very well. We want know what illnesses people, and especially women, suffer from, where do they go for help and how much is spent on seeking care. This study is being conducted in Jari Mari, Mumbai, Nashik city and the villages of Igatpuri taluka. By conducting such a study, the experiences of many people can be brought together and we can gain a better understanding of the condition of the entire city or tehsil.

For this reason, we want to know from women about themselves and their family members' health. We also want information about events – deliveries, pregnancies, abortion and deaths which have occurred in the past year in the household. Without the consent of the respondent, this information will not be shared with anybody. At the end of the study, a detailed report will be written on the basis of all the information collected. No individual's name will be printed in this report. This report will be available for all to read. You will also be given a small summarised report. We hope that this study will give the people in the community more information about the status of health in their area. We will also be able to answer some questions that we have in our minds.

We have selected the households purely by counting the number of houses, and not with any other objective. By sampling, all kinds of people can be included in the study. However, you have a right to refuse to give the interview and also to refuse to answer specific questions. CEHAT and the individuals who have signed this letter promise you that this information will not be divulged to anyone else.

If you have any doubts, questions or suggestions, please call us, meet us or write to us.

Name of the investigator:_____

Researchers

Roopashri Sinha
Neha Madhiwalla
Sunil Nandraj
Amar Jesani (Co-ordinator)

(NOTE: This pamphlet has been translated from Marathi.)

SCHEDULE NO : _____

HOUSEHOLD EXPENDITURE ON WOMEN'S HEALTH IN MAHARASHTRA

Centre for Enquiry into Health & Allied Themes (CEHAT)
519 Prabhu Darshan 31 SS Nagar, Amboli Andheri, (w) Bombay 400 058.

The objective of the study is to document and analytically understand the extent of perceived morbidity, patterns of health care service utilization and expenditure incurred by households on women's health.

All Information provided and recorded in this schedule would be kept confidential & used for research purposes only. The names and identity of respondents will not be disclosed under any circumstances.

==========

NUMBER OF VISITS: _____ **DATES:** _____ **PLACE:** _____

INVESTIGATOR'S NAME: _____ **CHECKED BY:** _____

REMARKS:_____

==========

1) Respondents Name: _____

1a) Relationship to the head of the household: _____

1b) Religion: _____ **1c) Caste/Tribe:** _____

1d) Mother tongue: _____

1e) Address: House/ Bldg. No: _____ Street: _____ Locality: _____

Village / City: _____ District: _____ Pin Code: _____

SCHEDULE NO. : _____

FAMILY PROFILE

S No	Name	Sex	Relation with the head of the household	Age	Education	Marital Status	No of living children	a.Delivery b.Abortion c.Pregnancy	Method of family planning used	Illness in the last month	Illess in the last month (after probing)
1	2	3	4	5	6	7	8	9	10	11	12

ILLNESS CARD

Person's Name: _____ Household No : _____

S.No	Symp-tomes of illness and causes	Duration of illness (write dates)	If illness is chronic, since when	Type of health facility utilised and reasons for that	Type of treat-ment	Treat-ment taken after how many days	Effect on the illness	Reasons for non-treatment	a.distance from the house b.type of vehicle used c.who acc-ompanied	No of visits	For how many days was the daily routine of the ill person disrupted	For how many days the daily routine of other persons in the house disrupted? If so, whose?
1	2	3	4	5	6	7	8	9	10	11	12	13

ILLNESS CARD

Person's Name: _____ Household No : _____

Illness No	Doctor's fess	Medicine/ Injection/ Tonic/ Tablets	Expenditure on examination	Expenditure on hospitalisation	Expenditure on travel	Expenditure on rituals / prayers	Expenditure on special diet	Expenditure on gifts	Expenditure borne by family members	Other exp.	Total Expenditure	Items combined
1	2	3	4	5	6	7	8	9	10	11	12	13

Schedule No_____

PREGNANCY (ANC) / DELIVERY / ABORTION / POST NATAL CARE (PNC) CARD

Person's Name: _____ Household No:_____

1) EVENT *(circle whichever applicable)*: PREGNANCY / DELIVERY / ABORTION / POST NATAL CARE

2) Any problems / complications: _____

3) Presently residing : Natal home / Own home / Any other (specify) : _____

Event and place	Any complications	Health centre	Reasons for choice of health facility	Type of treatment given and by whom	a.Distance from home b.Type of vehicle used c.who accompanied you	Duration of stay in the health centre	No. of visits	For how many days was the woman's daily routine disrupted?	For how many days was the daily routine of other family members dirupted
ANC									
Delivery/ Abortion									
PNC									

EXPENDITURE INCURRED

Events	Doctor's fess	Medicine/ Injection/ Tonic/ Tablets	Expendi-ture on examina-tion	Expendi-ture on hospita-lisation	Expendi-ture on travel	Expendi-ture on rituals / prayers	Expendi-ture on special diet	Expendi-ture on gifts	Expendi-ture borne by family members	Other exp.	Total Expendi-ture	Items combined
ANC												
Delivery/ Abortion												
PNC												

SCHEDULE NO : _____

PHYSICAL INFRASTRUCTURE, ASSETS & INCOME

1) **No of years of stay in the city:** _____

1a) Native place:_____Village/town where you live for some months:_____

City where you live for some months:_____

1b) Reason for living in Nasik:_____

2 **Ownership of House :** _____ own/ rented/ pagdi/ landlord's/any other_____

2a) In whose name is the house? / House rent:_____

2b) No of rooms (including kitchen) :_____

2c) Area of the house : (in Sq.ft) _____

2d) Type of House: Roof _____ Wall _____ Floor _____

2e) Any other specific details:_____

2d) Persons residing : _____

3) Drinking water sources: _____

3a) Distance from the house:_____

3b) Time required to fill water:_____

3c) Where do you get water in the summer?_____

4) Toilet: Present within the House / Public Toilet / Open / Any other (specify) _____

4a) If open : _____

4b) Charges/ time for using the toilet:_____

5) Bathroom : In the House / Outside_____

5a) Bathroom/ Closed Mori / Open Mori / Any other (specify) : _____

6a) Where do buy your grocery from?

Grains	Ration	Market	Credit/ loan	Own farm
Rice				
Wheat				
Jowar/ Bajra				
Nachani				

b) How many times do you eat in a day?_____

c) Do you get enough food through the year?_____

d) If no then why and when _____

7) Assets in the household

7a) Productive assets: _____

7b) Any other assets: _____

7c) Other Assets: Vehicle _____ Television (B/W or colour) _____

Fridge_____ Radio_____ electricity(Yes / whether applied for)_____

Cooking fuel_____Type of cooking utensils_____

8a) Agricultural land/ any other occupation_____

8b) If yes what is the produce?_____

SCHEDULE NO : _____

SOURCE OF FINANCE

This has to be administered to those household who have spent money either on illness / ANC / pregnancy / abortion / delivery / contraception of the members in the household.

How did your household meet the expenditure incurred on health ?

Subject	Number	Source of finance							
		Own income	Any scheme	Credit	Debt	Loan	Property sold/ mortaged	From relatives (relation)	Any other source
	Men								
	Women								
Illness	Children								
Pregnancy									
Abortion									
Delivery									
Contraception									
Death									

1) Will the expenses incurred in future be recovered?_____

2) In case you are a labourer what was the loss in terms of work days and money?_____

3) In case you are a farmer what was the loss?_____

4) What was the interest at which loan was taken for old illness/ delivery/ death?_____

Period_____Method_____

Remarks: _____

Occupation and income of each individual in the household (excluding income from agriculture and animal rearing)

S. No	Name	Main occupation (Place, designation, type of work)	Other occupation (Place, designation, type of work)	Wages (No of working days in the month x wage)	Income from self employment/ business (yearly)	Salary	Rent / Interest (yearly) details	Pension	Any other source	Total income of the individual

Family business and occupation:_____

Yearly income:_____

Total income of the family:_____

Remarks: _____

SCHEDULE NO : _____

DEATH CARD

Name : _____ **Household No.** _____

1) **Date of death :** _____

2) **Cause of death :** _____

2a) **If cause of death due to illness *(give details)* :**

2b) **If cause of death due to abortion *(give details)* :**

2c) **If cause of death due to maternity related *(give details)* :**

2d) **If cause of death due to contraceptive used *(give details)* :**

3) **Whether registered :** _____

4) **Expenditure incurred**

4a) **Total expenditure incurred prior to death on treatment (if applicable) :**

4b) **Total expenditure incurred on ceremony, rites etc. :**

_____

Annexure 3
List of questions for probing
(to be probed for all women of 12 years and above in the household)

1. Pain in any part of the body
2. Trouble with eating and digestion
3. Problems with chest and breathing
4. Trouble with seeing, hearing and moving
5. Weakness and related problems
6. Mental stress
7. Any skin problems
8. Problems with passing urine
9. Problems of the genital organs
10. Problems related to menstruation
11. Problems with having children or during childbirth
12. Problems during intercourse
13. Problems while using contraception
14. Any injury or accident or bite

    Any other long term illness

Annexure 4

Map of Igatpuri Taluka showing selected villages

Source: Census of India

District Census Handbook, Nashik

CEHAT PUBLICATIONS (1991- 2000)

Selected list

CEHAT PUBLICATIONS (1991- 2000)

Selected list

Studies, Reports and Books:

(RA. 05) Nandraj Sunil, Anagha Khot and Sumita Menon, **Accreditation of Hospitals: Breaking Boundaries in Health Care**, Mumbai: CEHAT, January 1999, pgs.132. (Rs.107/-)

(RA. 04) Nandraj Sunil and Ravi Duggal, **Physical Standards in the Private Health Sector: A Case Study of Rural Maharashtra,** Mumbai: CEHAT, December 1997, pgs. 100. (Rs. 82/-)

(RA. 03) Iyer Aditi, Amar Jesani and Santosh Karmarkar, **Patient Satisfaction in the Context of Socio-Economic Background and Basic Hospital Facilities: A Pilot Study of Indoor Patients of the Lokmanya Tilak Municipal General Hospital, Mumbai,** Mumbai: CEHAT, October 1996, pgs.57. (Rs. 50/-)

(RA. 02) Nandraj Sunil and Ravi Duggal, **Financing of Disease Control Programmes in India,** Mumbai: CEHAT, February 1996, pgs.55. (Rs. 49/-)

(RA. 01) Duggal Ravi, **The Private Health Sector in India: Nature, Trends and a Critique**, Mumbai: CEHAT, January 1996, pgs.47. (Rs. 43/-)

(PA. 27) Jesani Amar, **From Philanthropy to Human Right: A Perspective for Activism in the Field of Health Care**, *Indian Journal of Social Work,* Vol. 59, Issue 1, (Special Issue *Towards People-Centred Development – Part 2*), January 1998, pp. 291-320. (Rs. 23/-)

(PA. 17) Duggal Ravi, Sunil Nandraj and Asha Vadair, **Health Expenditure Across States - Part I,** *Economic & Political Weekly*, Vol. XXX, No.15, April 15, 1995, pp.834-844. (Rs. 8/-)

(PA. 16) Duggal Ravi, Sunil Nandraj and Asha Vadair, **Health Expenditure Across States - Part II,** *Economic & Political Weekly*, Vol. XXX, No.16, April 22, 1995, pp.901-908. (Rs. 6/-)

(RB. 03) Iyer Aditi and Amar Jesani, **Medical Ethics: For Self-Regulation of Medical Profession and Practice,** Mumbai: CEHAT, October 1999, pgs.41. (Rs. 38/-)

(RB. 02) Jesani Amar, P. C Singhi and Padma Prakash, **Market Medicine and Malpractice**, Mumbai: CEHAT and Society for Public Health Awareness and Action, 1997, pgs. 175. (Rs. 139/-)

(RB. 01) Jesani Amar, **Laws and Health Care Providers,** Mumbai: CEHAT, January 1996, pgs.135. (Rs. 110/-)

(RD. 08) Conference Papers Vols. I, II, III, Papers Presented at the International Conference on Preventing Violence, Caring for Survivors, Role of Health Profession and Services in Violence, Mumbai: CEHAT, November 1998, pgs.619. {73 papers: pages 599 (Rs. 449/-) 20 abstracts: pages 20 (Rs.15/-)}

(RC. 06) CEHAT: Impact of **Globalisation, Women, work, living environment and Health,** Mumbai: CEHAT, May 2000, pgs. 150. (Draft) (Rs. 125/-)

(RC. 04) Jeyaranjan J and Padmini Swaminathan, **The 'Costs' of Work: Changing Perceptions of Health in a Region in Transition: A Study of Chengalpattu, TamilNadu,** Mumbai: CEHAT, October 1999, pgs.70. (Draft) (Rs. 60/-)

(RC. 02) Nandraj Sunil, Neha Madhiwalla,Roopashri Sinha and Amar Jesani, **Women and Health Care in Mumbai: A Study of Morbidity, Utilisation and Expenditure on Health Care in the Household of the Metropolis**, Mumbai: CEHAT, February 1998, pgs.93. (Rs. 77/-)

(RC. 01) Report of the Regional Consultation on Responding to the Target Free Approach, Pune: CEHAT, January 1997, pgs. 20. (Rs. 22/-)

Papers

(PC. 15) Jesani Amar, **Health, Section for the Women's Health and Development, WHO COUNTRY PROFILE: India,** Mumbai: CEHAT, 1998, pgs. 34. **(***Draft Submitted to WHO/VHAI***)** (Rs. 26/-)

(PC. 14) Iyer Aditi, **Women's Access to Health Care, Section C3.7 of the Women's Health and Development, Country Profile, India,** Mumbai: CEHAT, 1998, pgs. 46. *(Draft Submitted to WHO/VHAI).* (Rs. 35/-)

(PC. 13) Iyer Aditi, **Women's Reproductive Health, Section C3.7 of the Women's Health and Development, Country Profile, India,** Mumbai: CEHAT, 1998, pgs. 41. *(Draft Submitted to WHO/VHAI).* (Rs. 31/-)

(PC. 12) Iyer Aditi, **Leading Causes of Morbidity and Mortality, Section C3.1 of the Women's Health and Development, Country Profile, India,** Mumbai: CEHAT, 1998, pgs. 34. *(Draft Submitted to WHO/VHAI).* (Rs. 26/-)

(PC. 11) Bandewar Sunita, **Abortion: Cause for Concern in India, Even 25 years after Legalisation,** (Paper Prepared *Sixth National Conference of Women's Movement* at Ranchi, Bihar, December 28-30, 1997), Pune: CEHAT, December 1997, pgs.7. (Rs. 5/-)

(PC. 09) Gupte Manisha, Sunita Bandewar and Hemalata Pisal, **Abortion Needs of Women in India: A Case Study of Rural Maharashtra**, *Reproductive Health Matters*, No. 9, May 1997, pp. 77-86. (Rs. 8/-)

(PC. 08) Gupte Manisha, Sunita Bandewar and Hemalata Pisal, **Women's Role in Decision Making in Abortion: Profiles from Rural Maharashtra,** (Paper Prepared for *XIV International Conference of the Social Science and Medicine* at Peebles, Scotland, Sept 2-6, 1996), Pune: CEHAT, September 1996, pgs. 23. (Rs. 17/-)

Resource Material

(RM. 13) Message for Health, *(Twelve basic messages on Health),* Pune: CEHAT, pgs 6. (Rs. 5/-)

(RM. 12) D'Souza Lalitha, **Sexual Assault of Women and Girl Children: Collection of Medical and Forensic Evidence, Medical Treatment and Psycho-Social Rehabilitation, A Manual and Evidence Kit for the Examining Physician,** Mumbai: CEHAT, November 1998. (Rs. 100/-)

(RM. 08) Gupte Manisha, Sunita Bandewar and Hemlata Pisal, **Vaytha Streechi, Katha, Garbhapatachi,** Pune: CEHAT, 1997. (Slide show in Marathi) (Rs. 1500/-)

(RM. 06) Database on Health, MS-Dos 3.0 Version Mumbai: CEHAT, (Rs. 300/- + Rs. 10/- for outstation cheques)

(RM. 05) Unnecessary Use of Injections *(Poster)* (Single Colour, 20" * 15") (Rs. 1/-)

(RM. 04) Rational and Irrational Use of Intravenous Saline *(Poster)* (Two Colour, 17"* 22") (Rs. 5/-)

(RM. 03) Basic Requirements for Health *(Poster)*(Single Colour, 20"*30") (Rs.2/-)

(RM. 02) What Can we do for our Health? *(Poster)* (Single Colour, 20" * 30") (Rs. 2/-)

(RM. 01) Proper Health Care – Our Right *(Poster)*(Single Colour, 20"*30")(Rs 2/-)

Ford publications for dissemination:

(In an effort to more effectively disseminate findings from applied science research on emerging reproductive health issues in India and Nepal the New Delhi office of the Ford Foundation initiated a reproductive health working papers series. Published and unpublished working papers, together with major conference proceedings, are available on request. Recently the work of dissemination has been transferred to CEHAT Mumbai office)

CEHAT

(Centre for Enquiry into Health and Allied Themes)

Research Centre of Anusandhan Trust

CEHAT, in Hindi means "Health". CEHAT, the research centre of Anusandhan Trust, stands for research, action, service and advocacy in health and allied themes. Socially relevant and rigorous academic health research and action at CEHAT is for the well being of the disadvantaged masses, for strengthening people's health movements and for realising right to health care. Its institutional structure acts as an interface between progressive people's movements and academia.

CEHAT's objectives are to undertake socially relevant research and advocacy projects on various socio-political aspects of health; establish direct services and programmes to demonstrate how health services can be made accessible equitably and ethically; disseminate information through databases and relevant publications, supported by a well-stocked and specialised public library and a documentation centre.

Evolution of a collective voluntary effort is a process. A non-profit voluntary institution demands a strong commitment to the cause as well as the high standard of professional inputs. The research and other efforts made by a voluntary institution for the well being of disadvantaged people and their movements **ought not to be** of low standard. In fact, such work needs to be of as good quality as, if not of higher quality than, done by the institutions supported by the government and the private agencies. Strong commitment and the high quality of process and output are indispensable for a non-profit voluntary institution to bring the well being of the disadvantaged and the poor to the local, national and international agenda.

On principle, CEHAT does not regard society merely as ground for experimentation or as unexplored terrain for data gathering for intellectual exercises. While the methodology used for each work shall meet high academic standards, it is also kept in mind that it is only a tool for the advancing the social commitment. The social relevance of work is therefore given the crucial importance it deserves.

We are a multi disciplinary team with training and experience in Medicine, Life Sciences, Economics, Social Sciences, Social Work, Journalism and Law. CEHAT's projects are based on its ideological commitment and priorities, and are focused on four broad themes, (1) Health Services and Financing, (2) Health Legislation, Ethics & Patients' Rights, (3) Women's Health, (4) Investigation and Treatment of Psycho-Social Trauma. An increasing part of this work is being done collaboratively and in partnership with other organisations and institutions.

Anusandhan Trust is registered under the Bombay Public Trust Act 1950 (Registration No. E-13480, Mumbai) and under the Foreign Contribution (Regulation) Act, 1976 (Registration No.083780565). All Donations/grants to CEHAT must be in favour of the Anusandhan Trust.